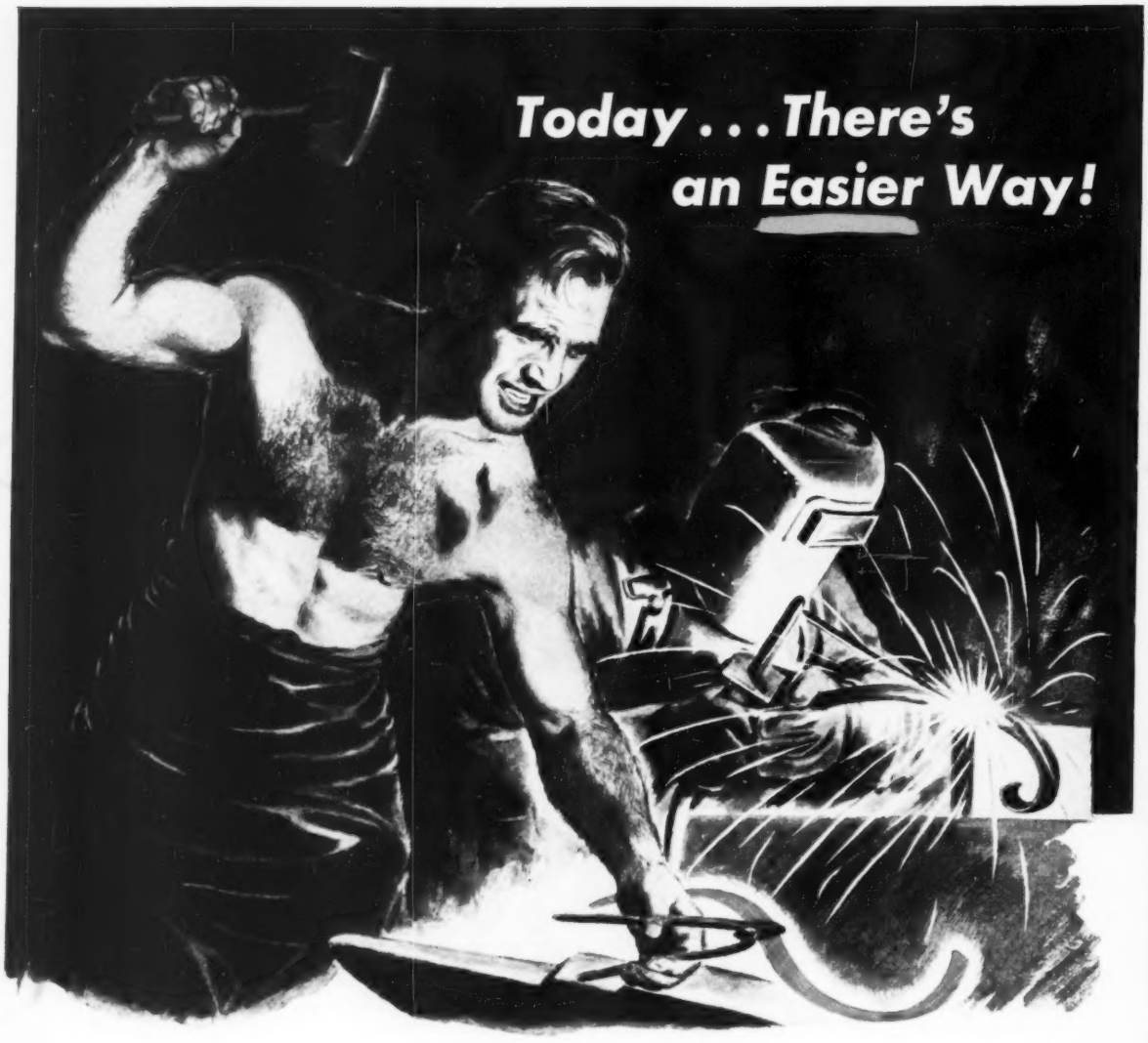
The Modern Hospital

MAY 1949

Round Table on Auxiliaries • Study of a Small Hospital • Family Night Program • New Health Bill Approved • Will Tomorrow's Hospital Be a Production Line? • Effingham Hospital Fire



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Ask your representative for a demonstration.

It took the Blacksmith's strong right arm *hours* to repair the broken wagon spring a hundred years ago. Today the same job can be finished in minutes—better, stronger—with modern welding.

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Out of our continuous study of group feeding, come products that are miles ahead of their forerunners—not only in finer, richer taste, texture and quality, but in ease, simplicity and economy of preparation.

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300 Products to Aid Restaurants and Institutions

- Gelatine Desserts
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- Cake Mixes
- Numerous Other Cooking Aids
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6 types of Koroseal sheeting meet all hospital requirements

KOROSEAL is more than a bed sheeting, it's an all-purpose hospital material.

Koroseal film, translucent or opaque white, can be folded, wrapped and twisted. Hospitals use this material for hot packs, wet dressings, pillow cases, sheets for examination tables and similar applications.

While the 6 types of Koroseal sheeting differ in appearance and suitability for specific hospital uses, they all have these qualities: they are waterproof, stainproof, not affected by mineral acids or alkalies, and they resist gasoline, methyl and ethyl alcohol and ether. They're durable, easily washed with common soap or regularly used cleaning agents. They will not become sticky or tacky, will not crack.

In all, there are six types of Koroseal sheeting:

No. 415 translucent film; 36" wide; gauge .004"

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No. 400 without fabric backing; 36" wide; gauge .015" (No. 401 is 45" wide; No. 402 is 54" wide)

No. 350 without fabric backing; lighter weight than No. 400; 36" wide; gauge .010 "(No. 351 is 45" wide; No. 352 is 54" wide).

No. 465 cotton fabric supported; 36" wide; double coated (No. 466 is 45" wide; No. 467 is 54" wide)

Make full use of this remarkable material. Order supplies of each type from your hospital supply house or surgical dealer. *The B. F. Goodrich Company, Sundries Division, Akron, Ohio.*

Koroseal—Trade Mark, Reg. U. S. Pat. Off.

Koroseal Sheeting BY

B.F.Goodrich

The Modern Hospital

MAY 1949

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Basic need is met when 'Surfacaine' (Cyclomethycaine, Lilly), as prescribed by the physician, is applied to damaged, irritated, or diseased skin and to rectal or genito-urinary membranes. Sustaining comfort is provided promptly and thoroughly, yet safely, with this new type of surface anesthetic.

Relief from pain usually lasts up to eight hours with 'Surfacaine.' However, it may be reapplied freely at shorter intervals, if necessary, and over extensive areas. Unlike topical analgesics whose value is sharply limited by high toxicity, 'Surfacaine' may be used liberally.

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Ointment 'Surfacaine,' 1 percent, in 1-ounce tubes with removable, perforated rectal tips and in 1-pound and 5-pound jars

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AMONG THE AUTHORS

Daniel G. Gill is credit manager at the Pennsylvania Hospital, Philadelphia, a position he took over when he entered the hospital field a little more than two years ago. The success of the methods described in his article on page 74 of this magazine is eloquently attested in the records of the hospital. "Since he came here, the department organized around Mr. Gill has increased ward patient income by about 33 per cent," another hospital official said recently. Before joining the hospital staff, Mr. Gill was a G-man, having worked with the F.B.I. during the war. Before that, he was a field investigator for the Bureau of Internal Revenue.

Mary E. Pillsbury, R.N., operates a rest home for ambulatory patients needing dietary and nursing care in Albuquerque, N.M., a field she went into several years ago after a number of years as a nursing executive in hospitals. Her last job was as nursing director of a 600 bed hospital in the East. Miss Pillsbury's textbook, "Nursing Care of Communicable Diseases," is now in its eighth edition. She is consultant to the New Mexico Health Foundation and chairman of the legislative committee of the New Mexico State Nurses Association. Her article on auxiliary nursing personnel appears on page 71.

Dr. C. Everett Koop, who writes in this issue of The MODERN HOSPITAL (page 86) about using a gelatin solution as a substitute for plasma, is assistant professor of child surgery at the University of Pennsylvania Medical School, chief surgeon on the staff of Philadelphia Children's Hospital, and assistant surgeon at the University of Pennsylvania Hospital. Dr. Koop's investigations with plasma substitutes, the relationship of nutrition to rehabilitation and convalescence, and problems associated with shock were first undertaken during the war, when he conducted clinical and laboratory research in these fields at the University of Pennsylvania.

Dr. Martin R. Steinberg was appointed director of New York's Mount Sinai Hospital last year after serving successively as assistant director, associate director and acting director. He went to Mount Sinai following service with the army medical corps, where he attained the rank of lieutenant colonel. Dr. Steinberg is a graduate of Temple University Medical School, Philadelphia. He had several years of postgraduate training in otolaryngology and became a diplomate of the American Board of Otolaryngology in 1934. Before the war, Dr. Steinberg practiced his specialty in Philadelphia.

Robert Penn became interested in hospital accounting in 1928 as a staff member of a national firm of public accountants. He received his C.P.A. degree in 1929, and is a member of the American Institute of Accountants, Illinois Society of Certified Public Accountants and other accounting associations. In May 1943, he was appointed cost accounting consultant to the Children's Bureau, U.S. Public Health Service, particularly in connection with the E.M.I.C. program, and served in this capacity until June 1946. In 1938 he formed the accounting firm of Robert Penn and Company, specializing in system installations and cost procedures and analyses for hospitals.

Reader Opinion

Just Isn't Worth It

Sirs:

The days are not long enough to crowd in all routine and emergency chores.

Am well into my eleventh year here and since 1938 this hospital has grown from 155 to 275 beds. We added 85 beds in 1943 and the rest a few at a time since then. To do a good job through an expansion program and the war, responsible for purchasing, stockroom, perpetual inventory and receiving and maintain good records, required the utmost in application. I have a receiving clerk and a stockroom man but no secretary or office assistant. I type all orders, write letters, file, run errands, inspect merchandise, listen to salesmen (sometimes with only one ear) and pass on all invoices for payment. Am interrupted at least 25 times a day by telephone and personnel seeking consultation on equipment or supplies. I work from 9 to 6:30 and on Saturdays until 4 at least—then take work home three nights a week.

Frankly, I feel that I have wasted ten years of my life in hospital work as there seems to be little reward, monetary or otherwise, and no recognition. My opinion of boards of directors could not be politely expressed on paper. I have had opportunities to move to other hospitals, but feeling that they are probably much the same, I have hesitated to break up my home here. Am negotiating now for what may be a good opportunity, not in a hospital but in an allied field.

Business Manager

Social Service Belongs

Sirs:

It was my privilege to attend most of the sessions of the Wisconsin Hospital Association conference recently and they were good. What I missed was any mention of the place of the medical social worker in the hospital set-up. If the nurse with her high school and three years of technical education is the "highly skilled trained nurse" who does so much for the patient, how about the professional social worker with a university training and two years' postgraduate work plus internship, who in her training specializes in psychology, law, psychiatry, community resources and human relations? Why aren't her contributions recognized as valuable?

The other day one of our doctors was telling me in the office about that well known case in a Chicago hospital recently where all the known medical skills were brought together in the treatment of a man whose condition is generally considered fatal. With the fusion of all these known skills and the expenditure of over half a million dollars the man's condition was controlled and eventually he was discharged as "cured" to his home. When he got there, he found that his wife, meantime, had begun living with another man and there was no longer a place for him. The shock and disappointment were so great and overwhelming that the patient went to the Chicago river and drowned himself!

I cannot help wondering how much of that outcome could have been changed if an adequate coverage by a skillful medical social worker had been active in the case: she could have become well acquainted with the man, his background, his family — perhaps made visits to his home or met his wife in her own office—may even have found out about the extramarital situation and been able to change that, or, at least, could have prepared the patient for it so that the shock could have not been there. Perhaps she could even have placed him elsewhere to begin life in another way from his former one. No one will ever know here, of course.

I wish it were possible for you to spend a couple of hours any day at any time in my office and listen in to the sort of things which come over my desk: Here comes a man whose wife has just told him she is going to have a baby by another man; here comes a man whose wife has an ailment and is unable to work—plans have to be made for the support of their family; here is a woman whose 15 year old daughter is keeping bad company and the father is an alcoholic; here is a young man who cannot decide whether to take thorocoplasty or not because his "girl friend" objects on the grounds that he will be left a "cripple"; here is a

child ready for discharge whose parents do not have adequate housing for his return into the home! So it goes—never the same thing twice! These are all problems that go with the treatment of disease!

During the conference there was much talk about treatment of disease. No mention was made of the patients as "people!" People have other problems besides their bodily aches and pains: they have emotional, economic, legal problems. Who is taking care of them? Can the doctor who is as busy as all of our doctors are? Can the nurse? What skills do either have and how much time can they give to these problems? Yet, many times the outcome of the medical treatment depends in large measure upon the patient's ability to relax, be at ease and not worry.

There are many people in our society now who believe that more is needed to "prevent" the disintegration of a family, or of a person, than the medical care now given: that more psychiatry and psychosomatic medicine are badly needed, and so I was a little surprised not to hear even a mention of any of these things at a conference covering such a large area and bringing so much professional knowledge and understanding to the conference as I found there.

Emma L. Stein

Milwaukee

How Many Beds?

Sirs:

An idea has occurred to me in connection with The MODERN HOSPITAL and I will pass it along to you for whatever it may be worth. I am wondering if it would be a good idea to show the number of beds in the hospital in the heading of an article when the article deals with a procedure or technic in one individual hospital. It seems to me that it might be a real service to readers to let them know, right at the outset, the size hospital that is being discussed.

As an example of what I mean, when the February issue arrived, I immediately turned to page 96 to read J. A. Blaha's article on food service because we happen to have a food service problem at the present time. As I read along through the article I wondered what size hospital he was talking about. Finally, in the last paragraph, on page 96, when I reached the statement in regard to nourishment carts, "this cart makes the rounds of the hospital . . ." I decided that I had to know the size of the hospital and got out my directory and looked it up. I believe that readers would appreciate having this knowledge in advance and that the material in the article would be of greater interest to them if they could think of it in relation to its applicability to their own hospital as they read the article. Maybe the size of the hospital does appear later on in the article—I haven't finished reading it yet.

Richard J. Hancock
Administrator

Lawrence and Memorial
Associated Hospitals
New London, Conn.

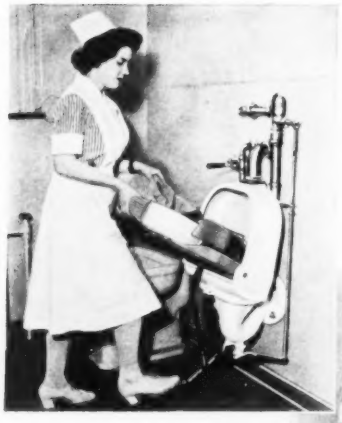
Those V.A. Hospitals

Sirs:

On page 57 of the March issue of The MODERN HOSPITAL Valdemar H. Paulsen states that there will be 450 qualified applications for admissions to the new Newark, N.J., 1000 bed V.A. hospital. With due consideration of the extended stay of the average V.A. patient, this represents an expected occupancy of about 25 per cent. Don't they even try to justify their building program any more? Or, now that the

AEROFLUSH

pioneers a sanitary *"Hands-off"* technic



SOILED BEDPAN AND URINAL CARE BECOMES AS SIMPLE AS 1-2-3

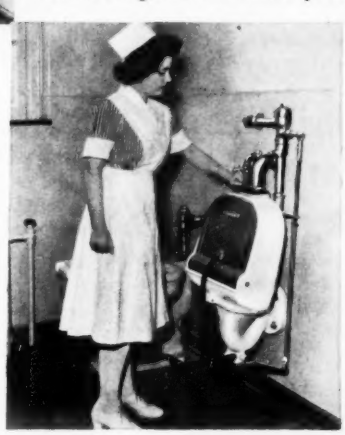
❶ **Foot-operated pedal quickly lowers cover for reception of bedpan or urinal. Cover closes silently against hydraulic cushion automatically emptying bedpan.**

❷ **Foot-operated flush valve washes automatically for approximately 30 seconds with penetrative *air-entrained* cold water. Foot pedals provide against accidental flushing before cover is closed.**

❸ **Forearm operates steam valve to disinfect bedpan or urinal. Release of handle automatically closes valve. *Operator's hand need never touch the Aeroflush Unit throughout the entire procedure.***

WALL MOUNTABLE BUILT-IN and PEDESTAL TYPES are available.

For Washing Only—The advantages of the "Aeroflush" technique are preserved in the Aeroflush Bedpan Washer where direct steam is not available for disinfection.



CONTINUOUS ODOR DISPOSAL by aeration. This exclusive feature—found only on Aeroflush—insures that the unpleasant odors associated with bedpans are promptly carried off through vent stack.

WRITE TODAY for detailed specifications

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DESIGNERS AND MANUFACTURERS OF SURGICAL STERILIZERS, TABLES AND LIGHTS

war has been over for almost four years, are we expected to believe that the service-connected hospitalization will increase?

As a citizen and a veteran with an intimate knowledge of what the V.A. is doing to my income tax, it burns me up to see five pages in your magazine devoted to "functional efficiency" by anyone connected to this government agency. I suppose its muddled affairs, gross extravagance and utter waste of manpower are nothing, though, compared to the new health program which is hanging over our heads.

Probably the Newark V.A. hospital will eventually be used to normal capacity (if the supply of hospital personnel holds out) but the point that irks me is that by their own admission only about 25 per cent of capacity will represent *qualified* patients. And, when they are ready to service those fellows, the qualified census in other V.A. hospitals will drop. In other words, instead of following the dictates of Congress by admitting nonservice-connected cases only when the veteran cannot afford hospitalization and there is a bed available, they have been successful in having a huge building program approved to make darn sure there will be beds available and they have no scruples about dodging the economic status of the veteran. There is no legal reason for the V.A. to operate on their present scale and it cannot justify an increased demand for their hospital services in the future.

You know all this and the A.H.A. made certain at its last convention that the government knows how the association feels about this political racket. I just had to blow off a little steam and the article in your excellent magazine steered it in your direction. You may print any part of my opinions of this bureaucracy. My eyes were opened to its reputation while I was in service. As registrar of one of the U.S. Army Hospital Centers I had to discharge my disabled veterans by transferring them to the Veterans Administration facilities. To my horror I learned from the attendant who accompanied these cases that the men remained there just long enough to substantiate a receipt to the army. They would walk in the front door and out the back door if they were able. Since then the medical care has improved somewhat, but the administration is worse from an economic standpoint.

Bentley Frederick
Administrator

Children's Hospital
Louisville, Ky.

There Should Be More

Sirs:

The article by Miss Geister in the August issue of The MODERN HOSPITAL (The Hospital and the Nurse) is one of the finest I have ever read. She has the keenest insight into all nursing problems and is one of our real leaders. You are to be congratulated on printing it. We need more "Janet Geisters." She thinks of everyone in her analyses.

K. S.

Ohio

Injustice to Industry

Sirs:

I have read the article in The MODERN HOSPITAL, February 1949 issue, entitled "Early Ambulation Costs Less." I think that a good deal of thought has been given to this article and the theory is very good. However, I do think the author has done an injustice to the textile industry. He has quoted 1938 and 1947 prices and has not made a comparative price in similar quantities.

I am quoting below the prices given as compared with prices on the same commodities during the same time in equal quantities in the same ratio.

These prices have been checked by one of the largest buyers in this community on their supplies.

Curtis W. Miles

*Table I Shows**	*1938*	*1947*
Adhesive per roll	*1.10—150 roll 1.10—150 roll	*2.85 — 25 roll lots 2.65—150 roll lots
Plaster of Paris bandages	*1.70 1.99	*3.60 3.37 — all 36 doz. price
Gauze sponges	*5.60 per 1000 5.60 per 1000	*28.65 per 2000 13.20 per 1000 in 20 case lots (2000 to a case)
Sheets	*7.89 doz. 8.08 doz.	*24.48 doz. 22.09 doz.
Pillow cases	*2.11 doz. 2.23 doz.	*6.60 doz. 6.10 doz.
Wash cloths	* .47½ doz. .44 doz.	*1.26 doz. .99 doz.

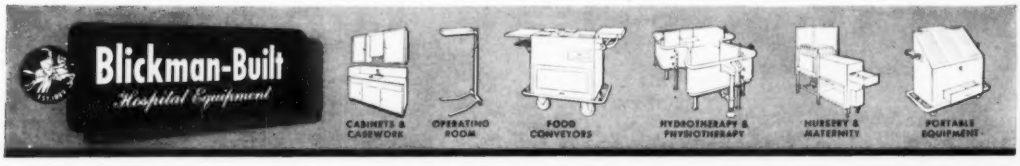
The March issue of "Trends" featured the new "selective menu"—an idea which is being adopted by many progressive hospitals. The April issue deals with new techniques and equipment for the Nursery. Send for copies of these issues, if you have not already received them.

New developments in hospital equipment... PRESENTED FOR YOU IN "TRENDS"

Visit us at Mid-Atlantic Hospital Convention in Atlantic City, May 18-20

"Trends" is a new publication issued as a service to hospital officials by S. Blickman, Inc. It is designed to keep you in touch with the latest developments in hospital equipment. "*Trends*" contains basic facts about materials, design and construction to help you establish standards for durability and sanitation. It discusses new techniques and shows equipment especially adapted to these techniques. "*Trends*" is published monthly and sent gratis to hospital administrators and other executives interested in the selection and purchase of equipment. Ask to be included on our mailing list.

Please address inquiries on your letterhead to: Editor — "Trends"
S. BLICKMAN, INC., 1505 Gregory Avenue, WEEHAWKEN, N. J.



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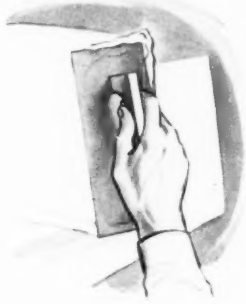
1

QUICK, EASY PRIMING — The Lockart Method permits direct application right over plaster, brick, metal, concrete or plaster wall-board. First, a coat of Lockart Primer is spread over the wall surface.

2

THEN—LOCKART EXPANSET FOR PERFECT ADHESION—Expanset is a clean, white cement suitable for all types of ceramic tile. Either the Float-Bed or Buttercoat method of setting may be used.



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FAST APPLICATION . . . FAST SETTING—This modern, streamlined way of installing Mosaic tile speeds up the work—and costs less!

Today Mosaic's exclusive LOCKART method is being used for tile installations from coast to coast—in modernizing all kinds of areas in all types of buildings.

The LOCKART method saves you time, money and labor. Application costs on new work are reduced as much as 30%. You'll save up to 40% on renovations. You get rooms back into service in record time, or complete new work *faster*.

NO METAL LATH OR SCRATCH COAT REQUIRED

No structural changes are necessary with Mosaic's LOCKART method. Furthermore, there's no dirt—no mess. And LOCKART Expanset dries fast and reduces the load on the wall as much as 50%. Shear tests conducted by the U. S. Testing Laboratories demonstrated that Mosaic tile, attached to plaster wall-board with the LOCKART method, withstood shearing pressure equivalent to about 2800 lbs. to the square foot!

REDUCE MAINTENANCE WITH MOSAIC TILE

Distinctive Mosaic tile installations offer beauty that doesn't fade or need renewing . . . assure years of heavy traffic without upkeep. Use Mosaic's wide line of ceramic tile to modernize bathrooms, rest rooms, kitchens, corridors, lobbies, etc. Mail the coupon today or consult the Mosaic dealer or office nearest you.

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Zanesville, Ohio — *Member: Tile Council of America*

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GENERAL FOODS CONTESTS

32 Hotel and Restaurant Executives and Employees Win Awards Worth 740,000 Premium Points for Prize Menus and Merchandising Ideas

1st PRIZE WINNER
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Mrs. Frances Tegtmeier
Co-Manager
Bismarck Cafe
20 West Main Street
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1st PRIZE WINNER
Lunch Menu Contest:
Mrs. Jean Thomson
Service Representative
Hotel Brunswick
Queen and Chestnut Streets
Lancaster, Pennsylvania

1st PRIZE WINNER
Merchandising Idea Contest:
Mrs. Royce B. Adamson
Owner
Royce Cafe
402 South Broadway
Edmond, Oklahoma

1st PRIZE WINNER
Dinner or Supper Menu Contest:
Richard T. Kreuzburg, Partner
Mrs. K's Toll House Tavern
9201 Colesville Road
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1st PRIZES: 4 all-expenses-paid trips for two to 1949 National Restaurant Association Convention at Atlantic City, N. J., including Pullman, air, or bus fares, hotel for 5 days, tickets for all important functions, and $200 spending money. (Alternate prize 100,000 premium points.)

. . .

TOUGH PICKING THE WINNERS! Hundreds of constructive ideas for improving menus and for merchandising food were submitted in the 1949 General Foods 4 Big Prize Contests. Reuben H. Donnelley Corp., nationally known contest judges, gives the nod to these 32 contestants for the finest entries in a top-notch field.

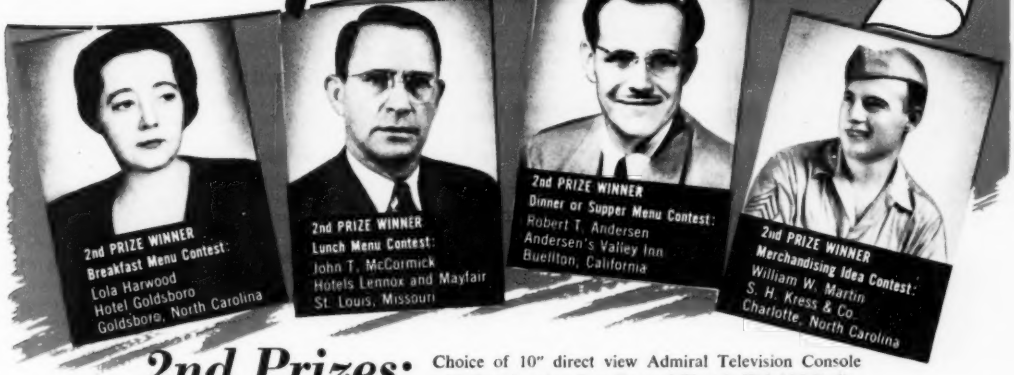
They chose them on the basis of standards suggested by the quintet of public feeding authorities: Charles A. Horrworth, Executive Vice President, American Hotel Association; Frank J. Wiffler, Executive Vice President, National Restaurant Association; James S. Warren, Editorial Director, Ahrens Publications; C. A. Patterson, Editor and Publisher, American Restaurant Magazine; and J. Knight Willy, Publisher, Hotel Monthly.

Winners were picked in 4 individual contests—for the best breakfast menu, lunch menu, dinner or supper menu, and for the best merchandising or food selling ideas other than menus.

Thanks to all for making the second General Foods Prize Contest an outstanding success. To everyone who entered we've sent along 90 premium coupon points, good toward any of the many prizes available under General Foods continuing premium coupon plan.

PEOPLE WHO TALK ABOUT GOOD FOOD . . .

SEND 4 TO ATLANTIC CITY



2nd Prizes: Choice of 10" direct view Admiral Television Console with "magic mirror" or General Electric FM-AM Radio-Phonograph Console, with genuine mahogany cabinet and automatic record changer. (Alternate Prize–50,000 premium points.)

20 OTHER PRIZES

(2,000 Premium Points Apiece)

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Burlington, Vermont
J. Spencer Lloyd
San Antonio, Texas
Henry Aline Alexander
Fort Worth, Texas
Tom G. Stargel
Oklahoma City, Oklahoma
Earl Abel
San Antonio, Texas

LUNCH MENU CONTEST:
Lucile Hicks Neff
Salem, Virginia
Edwin S. Elgin
Springfield, Illinois
Alan T. Hudson
Chicago, Illinois
Willis F. Hawkins
Los Angeles, California
Alex Parker
Raleigh, North Carolina

DINNER OR SUPPER MENU CONTEST:
Victor B. Gilbert
Ridgefield, Connecticut
Emil W. Foust
Newport Beach, Calif.
C. B. "Bill" Knapp
Battle Creek, Michigan
Victor H. Semos
Dallas, Texas
Mrs. Ike Davis
Meridian, Mississippi

MERCHANDISING IDEA CONTEST:
Mrs. Anna Hollett
Princeton, Missouri
Morris H. Auerbach
Jersey City, New Jersey
Clara Nobinsin
Milwaukee, Wisconsin
Leslie H. Moore, Jr.
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Ralph S. Nohlgren
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3rd Prizes: Sets of famous Tommy Traveler Luggage–two-suiter and 21" cases, both top grain cowhide with double stitched cowhide binding. (Alternate Prizes–25,000 premium points.)

3RD PRIZE WINNERS

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Ace Foods Inc.
Milwaukee, Wisconsin

Lunch Menu Contest:
U. P. Harris
Harris Good Food
Grand Junction, Colorado

Merchandising Idea Contest:
Fred Elias
Dixie Drive-In
Hazel Park, Michigan

Dinner or Supper Menu Contest:
Botho Kohlweck
Paso Robles Inn
Paso Robles, California

HOSPITALITY:
Enjoy it at General Foods Progress Inn in the Idea Center N.R.A. Convention, Atlantic City, May 24-27. There'll be talk aplenty about the prize-winning menu and merchandising suggestions.

...TALK ABOUT GENERAL FOODS!

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INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—26th Edition

Picture shows Wear-Ever Chairs in Younker's Tea Room, Des Moines, Iowa.

THIS CHAIR PAYS DIVIDENDS 2 WAYS

. . . in customer approval
. . . in lasting durability

It is posture-designed for comfort. Legs are self-leveling. Its smooth, splinter-proof surfaces can't snag stockings. Lightweight for easy handling. Silvery alumilite finish won't show fingermarks, won't chip, crack or peel. Durable, washable upholstery fabric: red, blue, white, green, brown and dark green. See your supply house or mail coupon. The Aluminum Cooking Utensil Company, 705 Wear-Ever Building, New Kensington, Pennsylvania.

Matching Pedestal Tables. *Formica tops, many colors, square, oblong, round styles, in all sizes.*

STURDY

* A Wear-Ever Chair with a 200 lb. load on it was rocked 100,000 times with a 4½" drop on each "rock". At the end of this test it was still as solid and tight as new.

WEAR-EVER ALUMINUM TRADE MARK REG U.S. PAT OFF

WEAR·EVER *Aluminum Chairs*

We would like to see the New Wear-Ever Aluminum Chair:

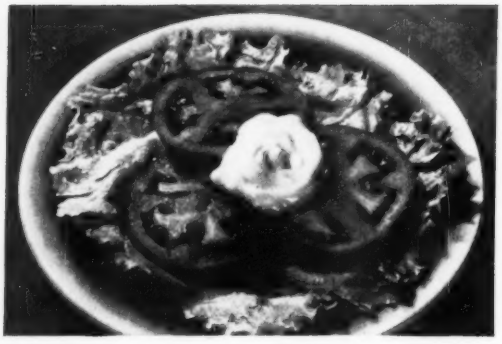
Color . . . . . Also price on (Quantity) . . . . . .

NAME . . . . . TITLE . . . . . .

FIRM . . . . . .

ADDRESS . . . . . .

CITY . . . . . ZONE . . . . STATE . . . . . .



Salad Magic

THAT BUILDS A REPUTATION!

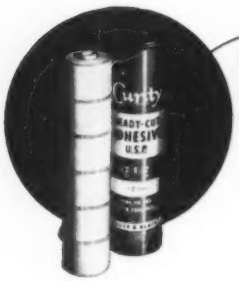
GOOD salads are one sure signpost of a good place to eat. And since your "salad reputation" depends so greatly on the dressing you use, it is false economy to top good salad makings with less than the best!

- Prepared from famous Heinz White Vinegar, blended with selected eggs, fine oil and other choice ingredients, Heinz 57 Salad Dressing points up the flavor of your salads to perfection.
- Ask your Heinz Man to show you the many advantages of using famous Heinz 57 Salad Dressing.

Ask Your Heinz Man About

HEINZ 57
Salad Dressing

It's not just the adhesive...
It's the kind of cloth the adhesive is on



NO WRINKLE...
NO CRINKLE...NO CURL

As you know, CURITY Adhesive Tape has long been known for its "stick-to-it-iveness" and lack of skin irritation. But equally important, CURITY adhesive is made with a special cloth backing which makes it easier—far easier—to handle.

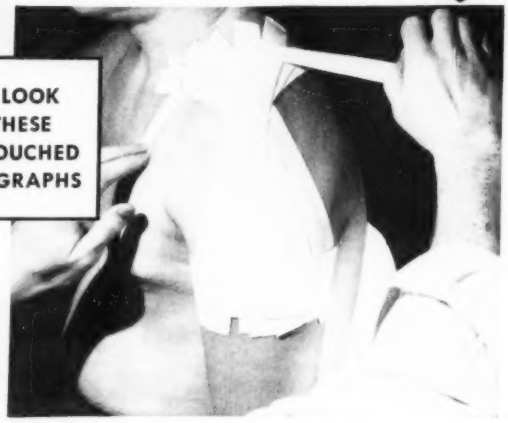
If you have ever been slowed down because limp, droopy tape wrinkled or stuck to itself as you applied it, just try a roll of CURITY. See for yourself how the special cloth backing of CURITY adhesive gives it more "body"—makes it easier to handle because it goes on smoothly, lies flat.

What's more, the same special cloth that makes CURITY adhesive easier to apply also reduces stretching, gives longer support... you have to retape less frequently with CURITY adhesive.

Here is the kind of wrinkling difficulty you encounter, to a greater or lesser degree with ordinary tapes.

JUST LOOK AT THESE UNRETOUCHED PHOTOGRAPHS

Note the smooth application of CURITY adhesive because of the special CURITY cloth.



A product of

BAUER & BLACK

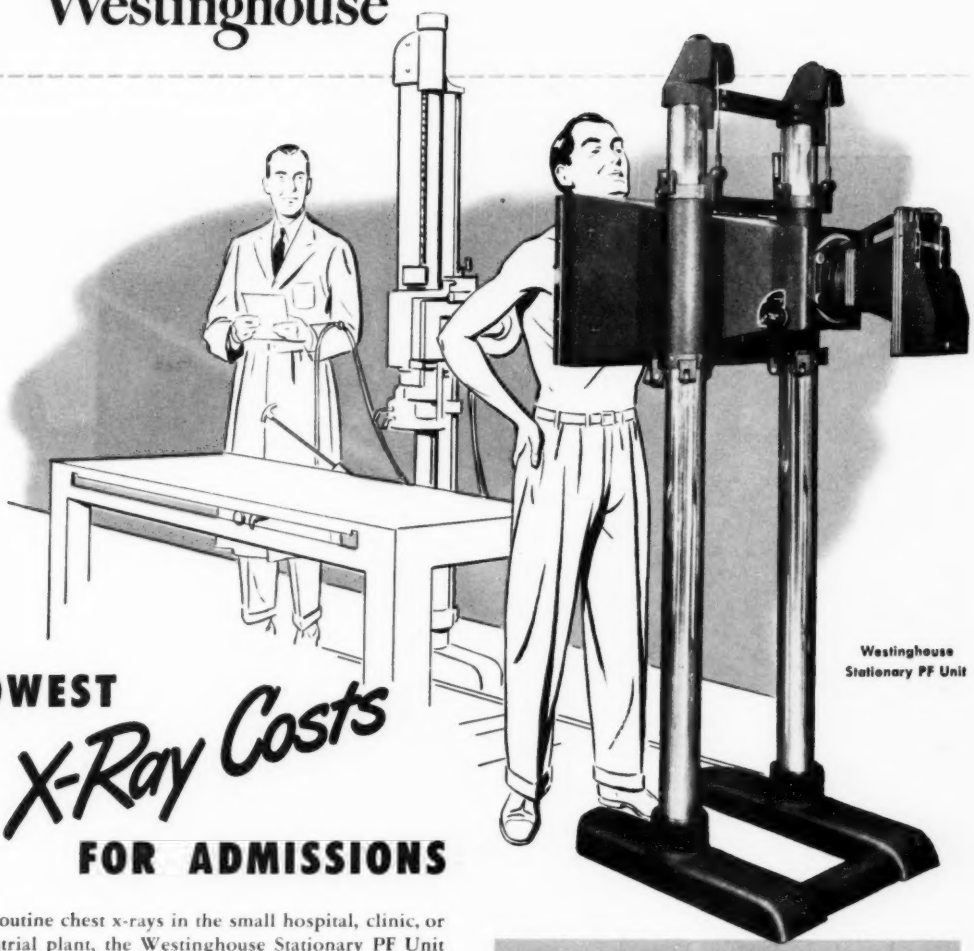
Division of The Kendall Company, Chicago 16

RESEARCH TO IMPROVE TECHNIC...TO REDUCE COST

Curity
REG. U.S. PAT. OFF.

YOU CAN BE **SURE**.. IF IT'S

Westinghouse



Westinghouse Stationary PF Unit

LOWEST *X-Ray Costs* FOR ADMISSIONS

For routine chest x-rays in the small hospital, clinic, or industrial plant, the Westinghouse Stationary PF Unit and 70 mm Cut-Film Camera offer the lowest over-all cost of any system available.

Look at these advantages:

- **Lowest initial cost for equipment.**
- **Use with present equipment.**
- **No special darkroom equipment required.**

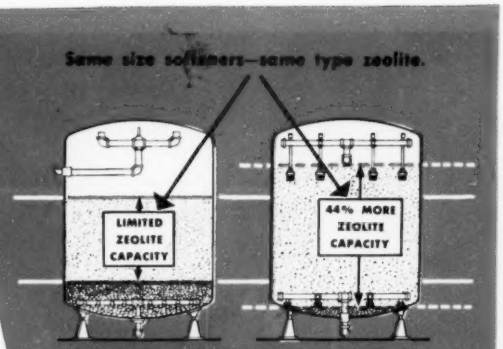
In addition, the Westinghouse Stationary PF Unit offers these operational features:

- **Immediate development and study of film.**
- **No change in existing filing system required.**
- **Choice of 35 mm roll film or 70 mm cut film.**
- **Single or stereo cut film.**

For full information on the Stationary PF Unit, or on the completely automatic Westinghouse 35 mm and 70 mm PFX Chest Survey Unit, call your Westinghouse X-Ray Specialist today. Or, write Westinghouse Electric Corporation, P. O. Box 868, Pittsburgh 30, Pa. J-08217

Westinghouse X-Ray

9 out of 10 prefer the ELGIN "Double-Check" Water Softener!



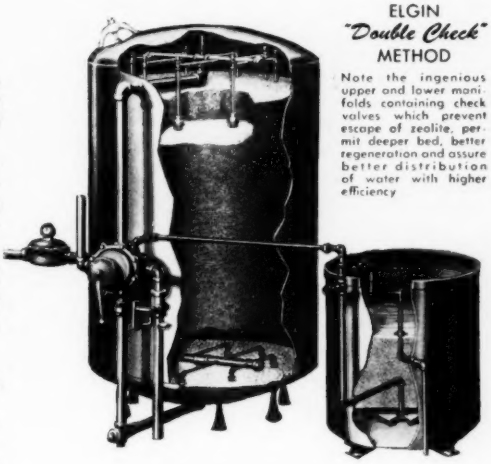
A record of the preference expressed by nearly 2000 operating men who weighed the Elgin "Double-Check" design against the conventional design, shows that 9 out of 10 prefer the "Double-Check"!

Study the diagrams above, contrasting the Elgin "Double-Check" design with the conventional zeolite water softener, and you will see why the "Double-Check" design is so overwhelmingly preferred. In comparison with the conventional softener the "Double-Check" means:

1. *More soft water.* Up to 44% more soft water from *same* size softener containing *same* type zeolite. "Double-Check" manifold permits putting more zeolite in a softener of given size; also permits higher back-wash rate which means more efficient use of the larger amount of zeolite.
2. *Eliminates zeolite loss.* By preventing escape of zeolite, the "Double-Check" design virtually eliminates zeolite replacement cost.
3. *Positive backwash control.* Backwash rate automatically regulated by Elgin backwash regulator.
4. *Less salt and wash water.* More efficient backwashing reduces wash water consumption; also assures more efficient regeneration that cuts salt consumption.
5. *Less maintenance.* Elgin quality construction means minimum repairs and replacements.
6. *Smaller space required.* More soft water from softener of given size means either added capacity from same size softener or same capacity from a smaller one

Ask for Bulletin 607. It shows why 9 out of 10 prefer Elgin "Double-Check".

ELGIN SOFTENER CORP., 144 North Grove Ave., Elgin, Ill.



ELGIN *"Double Check"* METHOD

Note the ingenious upper and lower manifolds containing check valves which prevent escape of zeolite, permit deeper bed, better regeneration and assure better distribution of water with higher efficiency

Step up capacity of your present softener

Remember that the Elgin "Double-Check" method is adaptable to all makes of softeners. Let us show you how we can step up the output of your present softener (as much as 3 to 10 times with the "Double-Check" method and our new high capacity synthetic and resinous zeolites).

ELGIN ECONOMICAL WATER CONDITIONING

GET THE FACTS . . .

Send Bulletin 607. I am interested in:

☐ Elgin Water Softener. ☐ Modernizing our water softener.

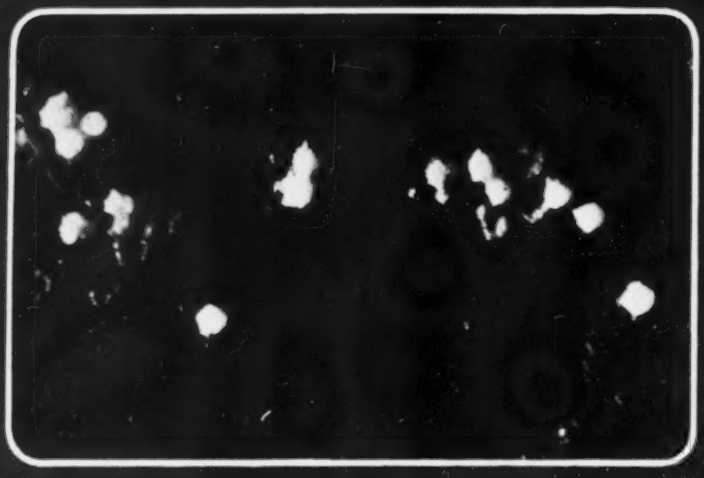
NAME_____

COMPANY_____

ADDRESS_____

Mail to—ELGIN SOFTENER CORPORATION, Elgin, Illinois

SOFTENERS • CHEMICAL TREATMENT • FILTERS • BOILER WATER CONDITIONING



Electron micrograph of herpes zoster—taken by the Division of Microbiology of the Squibb Institute for Medical Research. Gold-shadow technique produces 3-dimensional effect.

Shingles...

magnified 30,000 times!

● This remarkable electron micrograph . . . made by The Squibb Institute with the RCA Electron Microscope . . . reveals details of herpes zoster (shingles) virus heretofore seen only indistinctly with the light microscope.

Studies of micrographs like these lend support to the theory that the viruses of herpes zoster and varicella are identical, or so closely similar that they are indistinguishable. For example, micrographs of elementary bodies obtained from the vesicles of a typical herpes zoster case and a secondary case of varicella show them to be similar. (The record shows that cases of herpes zoster appearing in hospital wards were frequently followed by outbreaks of varicella among susceptible patients).

Here is another example of how the RCA Electron Microscope is opening new investigative possibilities in medical science.

• • •

For information about this important instrument . . . capable of magnifying 100,000 times with great depth of focus . . . simply write Dept. 97E.

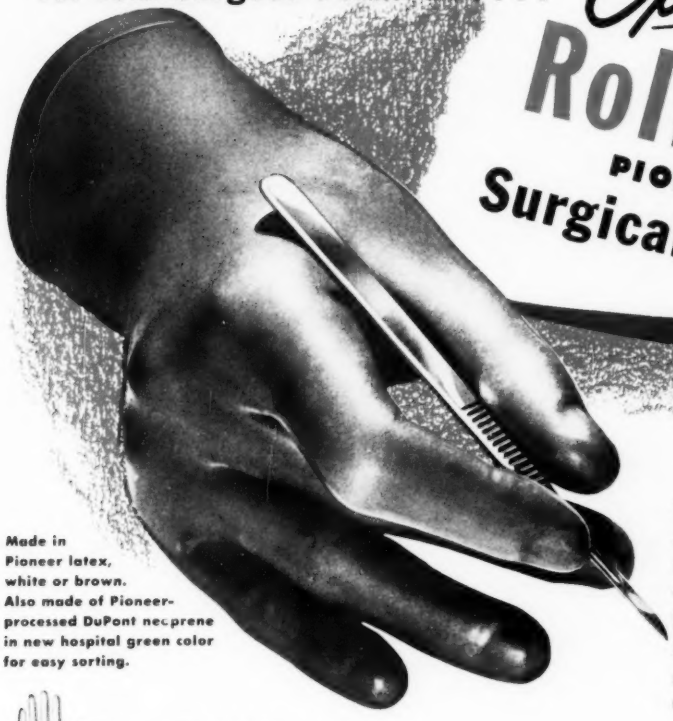
A Squibb technician at the controls of the RCA Electron Microscope. This instrument can magnify and resolve 50 to 100 times more than the light microscope.

SCIENTIFIC INSTRUMENTS
RADIO CORPORATION of AMERICA
ENGINEERING PRODUCTS DEPARTMENT, CAMDEN, N.J.

In Canada: RCA VICTOR Company Limited, Montreal

. . . To Be Sure of Unequalled Working Freedom for Your Surgeon's Hands . . . . .

Specify Rollpruf PIONEER Surgical Gloves



Made in Pioneer latex, white or brown. Also made of Pioneer-processed DuPont neoprene in new hospital green color for easy sorting.

You won't get a filmy gauze that breaks through at the first bend of a knuckle; but you will get a sheer, tough, top-quality surgeon's glove that relaxes unwrinkled on the hands, that's less tiring during long operations — when you specify Pioneer Rollpruf Surgical Gloves.

All Rollprufs offer the exclusive advantage of beadless flat-banded wrists, no roll to roll down and annoy at crucial points in surgery. Flat-banded wrists reduce tearing, add to the extra long glove life of Rollprufs, are more economical in the long run than inferior brands.

By specifying Pioneer Rollprufs you give your surgeons the best in antiseptic protection in a glove that allows them to retain almost barehand dexterity. It pays you to insist on Rollprufs. Specify the gloves your surgeons like — give your budget a break. Ask your supplier for Rollprufs — or write *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*

Pioneer Obstetricals
Made of finest quality latex, elbow length, sheer but tough. Either hand style so any two make a pair — saves pairing and odd gloves.

Pioneer Quixams
Either-hand short wrist examination glove, now made of finest quality latex or neoprene. Any two are a pair—less cost.

PIONEER *Surgical Gloves*

★ The Result of Over 30 Years of Quality Glove Making ★

"SMALL CHANGE" PAYS FOR *GREAT* PROTECTION FROM GERMS

Amphyl

Reg. U. S. Pat. Off.

PHENOL COEFFICIENT 10

• Only 2¢ pays for a gallon of ½% AMPHYL solution, the strength recommended for thorough disinfection of floors, walls, furniture, and all surfaces. AMPHYL is most frequently used in ¼% to 2% solutions.

Non-toxic • Non-injurious to human tissue • Mild, agreeable, clean odor • Concentrated potency for maximum economy • Effective in presence of organic matter • Powerful surface-tension depressant • Protection for instruments against rusting.

NON-SPECIFIC AMPHYL eliminates all necessity of maintaining supplies of several germicides for various specific purposes. Doctors already familiar with it praise AMPHYL highly for uses in surgery, obstetrics, gynecology, dermatology, dentistry, and unlimited general utility.

AMPHYL
destroys
more deadly germs
more quickly
more economically!

AMPHYL—List price, $5.00 per gallon. *Save 20%* by buying a 50-gallon drum. Supplied in 1-gallon containers and in 5, 10, and 50-gallon drums. Leading hospital supply distributors are authorized to sell AMPHYL.

WRITE for samples of AMPHYL and detailed monograph for the medical and dental professions to your

HOSPITAL SUPPLY DISTRIBUTOR
or to
LEHN & FINK PRODUCTS CORPORATION
Hospital Department
445 Park Avenue, New York 22, N. Y.

MODERN APPARATUS FOR *Resuscitation*

ADEQUATE treatment of asphyxia and oxygen deficiency in all types of cases demands modern equipment for resuscitation and for the administration of oxygen to meet varying conditions. Ohio-Kreiselman Resuscitators provide positive, reliable, safe control of gas pressure by automat and regulator equipment which provides three stages of automatic pressure reduction. Kreiselman resuscitators are made in two general types: one designed essentially for use in asphyxia neonatorum, and the other for use in resuscitation of children and adults. All models embody identical principles and when equipped with proper sizes of masks are complete and adequate for the treatment of infants, children or adults. The catalog, "Kreiselman Resuscitators," mailed on request, gives complete details. For immediate detailed information, call our nearest branch sales office.

OHIO HOSPITAL EQUIPMENT

Heidbrink Anesthesia Apparatus Ohio-Heidbrink Oxygen Therapy Apparatus • Kreiselman Resuscitators • Scanlan-Morris Sterilizers Ohio Scanlan Surgical Tables Operay Surgical Lights • Scanlan Surgical Sutures • Steril-Brite Furniture • Recessed Cabinets • U.S. Distributor of Stille Instruments.

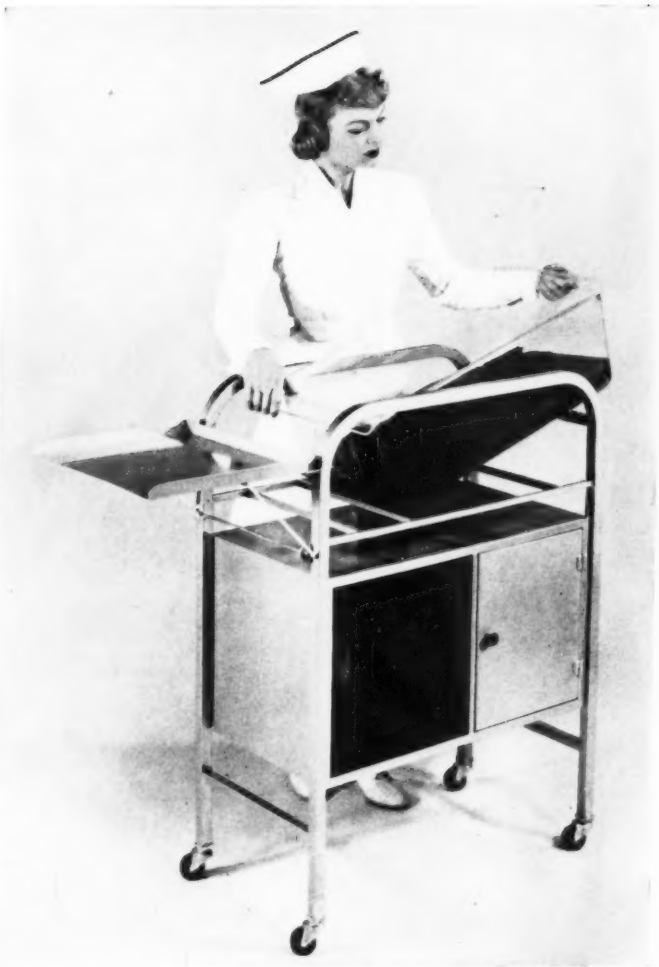
OHIO MEDICAL GASES

Oxygen • Nitrous Oxid • Cyclopropane • Carbon Dioxid Ethylene • Helium and mixtures • Also Laboratory Gases and Ethyl Chloride. Please return empty cylinders promptly.

Ohio Chemical OHIO

THE OHIO CHEMICAL & MFG. CO. 1400 East Washington Ave., Madison 10, Wisconsin
Branch offices in principal cities • Represented in Canada by Ohio Chemical Canada Limited, Montreal and Toronto, and internationally by Airco Corporation (International), New York 18.

NEW NURSERY EQUIPMENT FOR THE NEW ARRIVALS



Life-Long Bassinet No. 111-T (with flip-up tray) with Plastic Basket and Pillo—Foam Pad.

Life-Long Bassinet No. 111 (with slide out tray)

NEW LIFE-LONG INDIVIDUAL CARE BASSINETS

feature the latest ideas of pediatricians in advancing the isolation technique in the modern hospital.

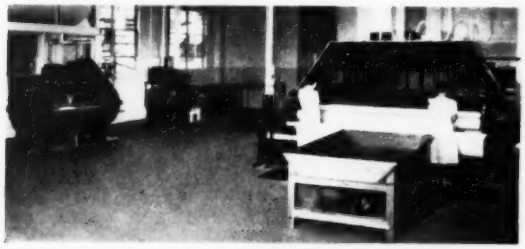
Crystal-clear and shatter-resistant, the Plexiglas Basket permits complete observation of the infant . . . and does away with troublesome basket liners.

Available in two models — Life-Long Bassinets may be adapted to a wide variety of specialized individual care. Sold through recognized hospital supply dealers.

HARD MANUFACTURING COMPANY
BUFFALO 7, NEW YORK

American

Modernized the Laundry Dept. at 75-Bed Orthopaedic Hospital, Los Angeles



In bright, spacious laundry department, are two NORWOOD CASCADE Washers, left. 4-Roll STREAMLINE Ironer, right, irons all linens.

American Extractor, right, removes water from washed work. Pieces not to be ironed, go to ZONE-AIR Drying Tumblers, left.

All uniforms and staff's personal apparel are neatly ironed on this SUPER-ZARMO, SUPER-ZARMOETTE Press Unit.

Problem

To insure efficient operation of expanded facilities from the start, Orthopaedic Hospital decided to modernize the laundry department first. Question: What size and type equipment to install?

Solution

Hospital called in our Laundry Advisor. He carefully analyzed present and anticipated requirements. Based on his findings and experience, he submitted recommendations and a suggested laundry layout. Latest, cost-reducing machines were installed in a new building.

Results

Plentiful flow of sterile-clean linens meets all requirements of increased hospital facilities. Laundering quality is outstanding. Equipment requires less operator effort; working conditions are improved.

***Large* or *small* hospitals may obtain the service of our Laundry Advisor, without cost or obligation. WRITE TODAY.**

Remember *Every Department of the Hospital Depends on the Laundry*

Your hospital will benefit by selecting from American's complete line of most advanced & productive hospital laundry equipment.

THE AMERICAN LAUNDRY MACHINERY COMPANY
CINCINNATI 12, OHIO

THE AMERICAN LAUNDRY MACHINERY CO.

Worried about Cross-Infection?

AIR-BORNE BACTERIA REDUCED OVER 90% AFTER A FEW SECONDS OF SPRAYING WITH

"MICROBOMB"* BRAND GLYCOL VAPORIZER

To help prevent cross-infection . . . to protect doctors, nurses, food handlers, patients, visitors.

To aid in sanitizing rooms after discharge of patients, permitting prompt re-occupancy.

SIMPLE . . . ECONOMICAL . . . EFFECTIVE

- quickly dispersed to all points of room
- no cumbersome, expensive apparatus
- one spraying—only a few seconds—effective for 6 to 8 hours
- Microbomb sufficient for 60 to 80 rooms at a cost of less than 3c per room
- non-toxic
- effective against streptococci, staphylococci, pneumococci and other air-borne pathogens

CARAND CORPORATION • RACINE, WISCONSIN

CARAND CORPORATION, Dept. MH4
RACINE, WISCONSIN

☐ Please send me information on "Microbomb"

☐ Ship me _____ doz.
(List Price, $34.68; Your Price, $20.80 per doz.)

BILL THROUGH _____

NAME _____

HOSPITAL _____ CITY _____ ZONE _____ STATE _____

Strong, Maneuverable, Versatile... the TOMAC OVERBED TABLE

Scores of hospitals wanted a versatile, single pedestal table—completely stable yet easily maneuverable *by either nurse or patient*. So AMERICAN produced the TOMAC Single Pedestal OVERBED.

Patients are so pleased with this table that they like to show visitors how it "works." The patient can easily raise or lower the top, locking it in any position for comfortable reading, writing or eating in armchair or in bed. A convenient make-up tray and mirror especially appeals to women, enables men patients to shave themselves.

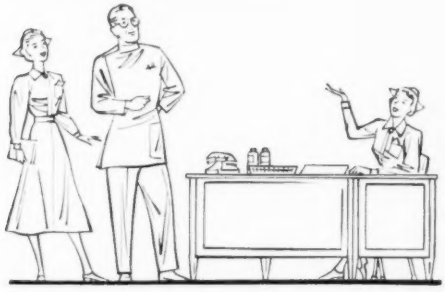
A Typical Product of AMERICAN

The TOMAC OVERBED TABLE is exclusively AMERICAN—typical of many AMERICAN products. It is further evidence of AMERICAN's leadership in conceiving and developing the better equipment, better supplies that make our hospitals the finest in the world. Use the new AMERICAN catalog as your source for your hospital needs.

PLAN WITH AMERICAN
... the first name in hospital supplies

AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES • EVANSTON, ILLINOIS

This low-cost ceiling will quiet your hospital

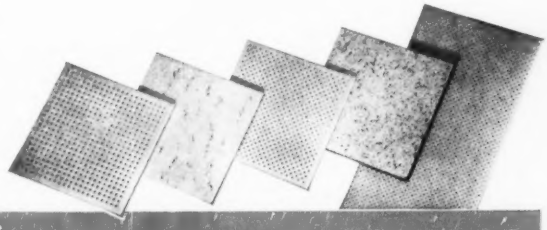


IF noise is disturbing the patients and staff of your hospital, there's an easy, low-cost solution to the problem. Acoustical ceilings of Armstrong's Cushiontone will absorb noise — and do it at a cost well within budget limitations. Cushiontone is low in cost and ideally suited to economical methods of application. Usually it can simply be cemented in place right over the existing plaster ceiling.

Armstrong's Cushiontone is a fiberboard acoustical tile, factory-painted white on face and beveled edges. It provides good light reflection, is easy to clean, and can be repainted again and again without loss of acoustical efficiency. Each 12" square tile of Cushiontone contains 484 perforations. Up to 75% of the noise that strikes the ceiling is absorbed immediately.

*TRAVERTONE IS A TRADE-MARK FOR WHICH REGISTRATION IS PENDING

If cost is vital in your selection of an acoustical material, Cushiontone is an ideal choice for economy. If high efficiency, beauty, incombustibility, or moisture resistance is a deciding factor, there's an Armstrong acoustical material stressing each one. Ask your local Armstrong acoustical contractor for full details or write direct to Armstrong Cork Company, 5705 Stevens Street, Lancaster, Penna.



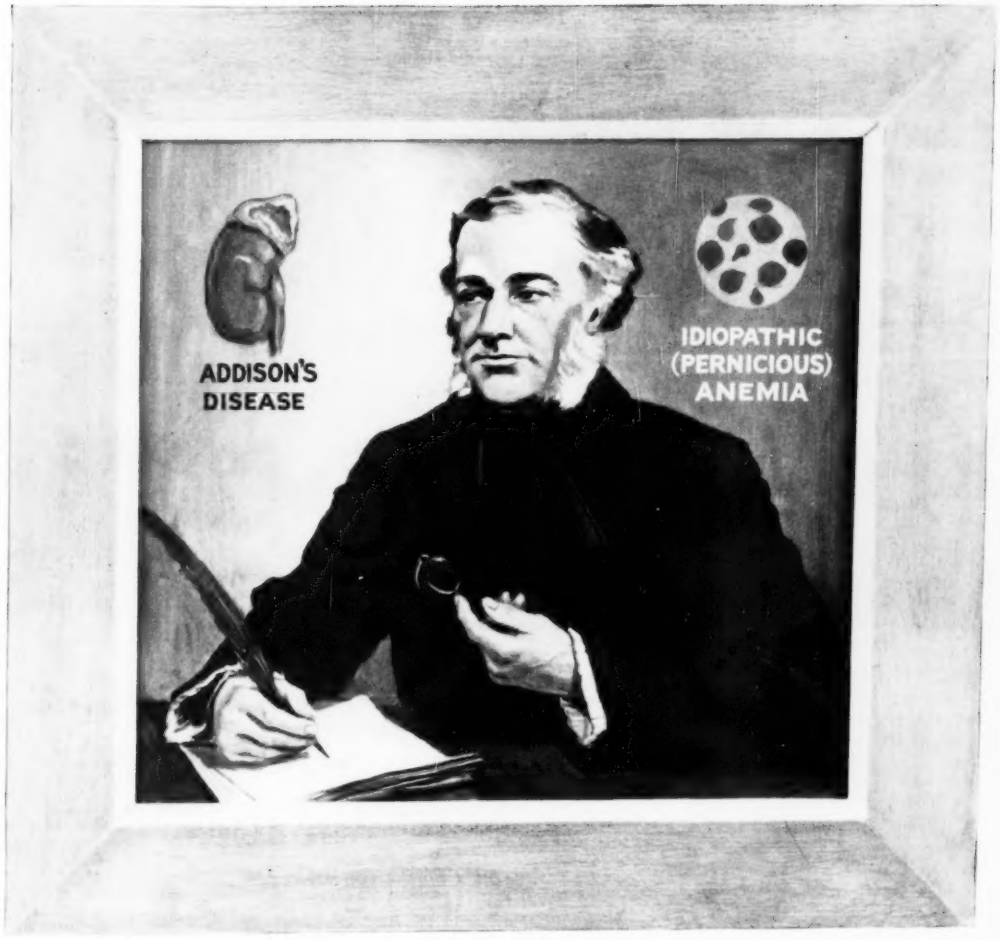
ARMSTRONG'S ACOUSTICAL MATERIALS

low-cost	*beautiful*	*incombustible*	*moisture-resistant*	*efficient*
CUSHIONTONE®	TRAVERTONE*	CUSHIONTONE F	CORKOUSTIC®	ARRESTONE®

The pioneer contributions by the eminent Thomas Addison in his study of the endocrines was a significant phase in the development of the field of Endocrinology. The Armour Laboratories, as a pioneer in this field, is keenly appreciative of Dr. Addison's early studies and illuminating descriptions.

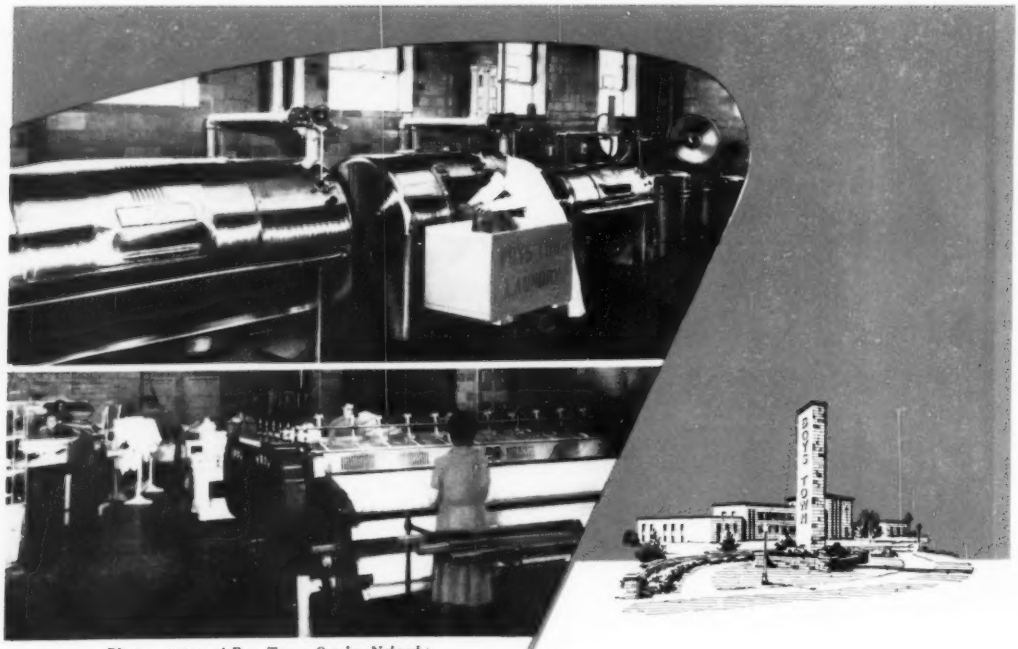
Ninth in the series, PORTRAITS OF PIONEERS in Endocrinology. A full-color reproduction of this painting, suitable for framing, is available upon request. On your professional letterhead, please address:

ARMOUR *Laboratories*
CHICAGO 9, ILLINOIS



Thomas Addison, M.D. 1793-1860

Thomas Addison's major contributions to medicine are bywords to every physician and student of medicine – but he, himself, is little known. Addison kept much to himself and was apparently wholly absorbed in the study, practice, and teaching of medicine. He was born at Long Benton, near Newcastle, England, in April 1793. He received his M.D. degree from Edinburgh in 1815. He became expert in skin diseases by working under the distinguished dermatologist, Dr. Bateman, at the Public Dispensary in London. In 1824 he was appointed assistant physician at Guy's Hospital, and in 1837 was made full physician and joint lecturer on medicine with the illustrious Dr. Bright. Addison published an essay "On the Operation of Poisonous Agents," and also a number of shorter medical articles, each of which displayed remarkable diagnostic acumen and attention to detail. He made extensive studies on pernicious anemia which he termed "idiopathic anemia" and which, to this day, is often referred to as "Addisonian anemia." At first he apparently confused this condition with "disease of the suprarenal capsules," which he described and which was subsequently named "Addison's Disease" by Trousseau.



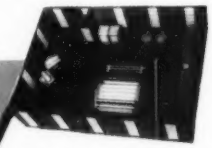
Photos courtesy of Boys Town, Omaha, Nebraska

Another Institution Installs

TROY Laundry Machinery for speed, convenience and reduced costs

WASHERS
EXTRACTORS
DRYING TUMBLERS
APPAREL PRESSES
FLATWORK IRONERS

In world-famous Boys Town, the care of hundreds of boys demands quick delivery of clean linens and wearing apparel with everyday regularity. Here, as in so many other institutions, Troy machinery provides the answer to the laundering problem. Troy laundry machinery is specifically designed to provide SPEED *and* CONVENIENCE *at* LOW OPERATING COST *in every phase of laundry operation. Linen and apparel inventories are kept at a minimum. Valuable time is saved and less labor is needed to turn out large loads. These are principal factors in the selection of Troy laundry machinery by both large and small institutions everywhere.*



TROY Laundry Machinery

DIVISION OF AMERICAN MACHINE AND METALS, INC.
EAST MOLINE, ILLINOIS

In Canada: American Machine and Metals (Canada) Ltd.
1144 Weston Road, Toronto 9, Ontario

"PHOTO-PLAN" SERVICE

Troy laundry engineers survey your needs and plan most efficient layout. Scale models of laundry machines are set up on a miniature of your floor plan, then photographed and an easy-to-read, three-dimensional photo is furnished to you. No charge for this Troy service. Write for details.

BUILDERS OF QUALITY LAUNDRY EQUIPMENT SINCE 1868

Small Hospital Questions

Salaries for Dietary Staff

Question: Are there any recent studies showing salaries paid to various kinds of employes in hospital dietary departments?—M.W., Iowa.

ANSWER: A recent survey of several institutions in one city showed the following rates:

HOSPITAL "A"	HOSPITAL "B"	HOSPITAL "C"
Dietitians—$210-265, 1 meal and uniforms and laundry	$225 minimum	$216.67-225.33, 1 meal
Chefs—$300	$300-365, 2 meals	$400, 2 meals, uniform, laundry
Cooks—$160-235	$250-290, 2 meals	$218.40-270.40, 2 meals, uniform, laundry
Pastry kitchen supervisors—$270	$235-300, 2 meals	$199.33, 2 meals, uniform, laundry
Waitresses—None	None	$112.66-117, 2 meals, uniform, laundry
Salad girls—$130	$140-145, 2 meals	$121.33, 2 meals, uniform, laundry
Pantry women—$115, 1 meal	$95-110, 2 meals	
Porters—$125, 2 meals	$125-165, 2 meals	$121.33-130, 2 meals, uniform, laundry

The Quality of Painting

Question: What important quality in painting should be looked for to minimize labor cost in painting?—J.B.B., La.

ANSWER: The quality of good brushing is essential in the case of any paint that will be used on large surface areas. A little extra "stickiness" or "pull" is to be expected in the case of high gloss enamels for use on furniture or other small areas; however, this condition is detrimental to speed of application in the case of flat paints for wall finish.—E. W. JONES.

Construction Costs

Question: Should hospital construction wait until costs go down?—R.C.M., Idaho.

ANSWER: Construction costs are roughly two and a half times what they were in 1940. The cost of any contemplated new construction should be estimated at this level. Efficient planning may reduce the cost to about twice the prewar figure, but any estimate of cost which is less than that amount is just wishful thinking and is going to lead to a revision of the plans after the bids are received.

Lower construction costs are not possible with the present type of construction, the wage scale and bonuses being paid the mechanics, and the inflated material costs.

Building costs probably will not go any higher. They may soon be a little lower but will definitely not reach the prewar level. Competition is being felt in the heavier construction field. More contractors are willing to submit firm bids. The outlook is encouraging, but those communities that believe they can wait out the inflationary period soon will find that they have been remiss in providing hospital facilities.

Substitute Materials

Question: Should substitute materials be used in a hospital building?—E.J.W., Ind.

ANSWER: Economies in construction design can be effected to reduce construction costs. Good engineering will provide the necessary amount of reinforcing to assure a sturdy structure, but some economies in the use of materials are feasible. Careful study will disclose means of reducing costs by effecting reductions in materials and fixtures.

Using substitute materials in some cases will result in a reduction in costs. However, some substitute materials have cost more than the original specified materials because of the building mechanics' inexperience in handling and erecting such new materials. Requests from contractors for permission to substitute materials for expediency, or as a means of reducing costs, should be given careful consideration. Their knowledge of the local market conditions is often valuable.

Laundry Costs

Question: Do you have any figures showing the relative cost of laundry per patient per day with hospitals operating their own laundry as against hospitals having their laundry done outside?—B.T., Calif.

ANSWER: Perhaps the most conclusive evidence that has been developed recently can be found in the Duke Endowment Year Book for 1948 giving facts and figures on hospitals in North and South Carolina which are aided by the Duke Foundation fund. Here is a tabulation taken from this report.

Hospitals operating own laundry	Hospitals that do not operate own laundry
Maximum—$0.51	Maximum—$0.80
Minimum— 0.14	Minimum— 0.17
Average — 0.28	Average — 0.42

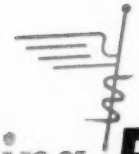
These figures check with others from various parts of the country and indicate quite conclusively that it is better to operate your own laundry. This is certainly true for any hospital of fifty beds and over. It may be that a hospital as small as twenty-five beds should be equipped to do its own laundry.

Alkyd Paints

Question: What is meant by alkyd paints?—J.B., Mo.

ANSWER: Alkyd means "alkyd resin" which is a chemical combination of soybean oil, glycerine and phthalic anhydride. This material gives one of the most durable, washable types of paint now known. To prove this point, alkyds are used in the finishes for refrigerators, automobiles, railroad cars, and for other purposes where extreme durability and washability are essential. —E. W. Jones.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.



Looking Forward

Ain't Necessarily So

ANNUAL meeting hospital here last night," said a postcard from our friend Anastasia, who is visiting in the provinces. "Big fuss old boy celebrating 25th anniversary president hospital board. My question, 'Is that good?' not popular under circumstances. Also not answered."

We sent Anastasia a wire right away: "Surprised your tactlessness. Old boy probably lives for hospital."

Anastasia's reply came on another postcard a few days later. "Question still not answered," it said.

Last Slim Hope

FEARS that we may be drifting toward the Welfare State or the Police State seem unrealistic alongside an ever-growing threat that few people are aware of: The fact is that we are already fast approaching the dread Public Relations State.

Early symptoms of the Public Relations State are seemingly harmless, yet they contain the seeds of the disintegration that follows. Releases, announcements, bulletins and memoranda abound. It is hard to say at what point their proliferation becomes malignant, but history teaches us that this always happens, and eventually all other forms of communication are choked off and disappear.

In the early stages, too, the steady increase in the number of committees, boards, conferences, workshops, assemblies and hearings is scarcely noticeable. Invariably, the populace is astonished to discover later that productive work is practically at a standstill as people rush from one meeting, or "contact," to another. For a while, too, the language that everyone uses, like "Implementation of the program at the local level will be effected as a joint responsibility of all the participating agencies," appears to mean something—an obvious hallucination.

The relentless multiplication of words, on paper and in the air, is, in fact, the key to the Public Relations State. Words become the principal currency, and, in obedience to Gresham's law, meaningless words circulate more freely than words that make sense, until finally the real words are driven out of existence. In the Public Relations State, everything depends on appearances. Morality vanishes; all considerations of right and wrong are replaced with "How does it look?" and "How does it sound?" Action gives way entirely to conversation; the state, literally, talks itself to death.

Plainly, we are already far advanced along this road to self-destruction; many philosophers and students believe we have gone too far to turn back. Whether this is true or not, all are agreed that our last slim hope for salvation lies in one desperate measure: We will have to *shut up!*

A Real Blow for Freedom

NEWS that the Missouri State Medical Association has approved changes in its constitution which will permit the admission of Negro physicians to membership will be welcomed by true friends of American medicine. The move should open hospital staff privileges and educational opportunities to a number of physicians for whom these privileges and opportunities have been sharply restricted until now. It is the patients of these physicians who have suffered most from the restrictions, of course, and who will be the principal beneficiaries of the change.

Similar action by medical societies, medical schools and hospital staffs everywhere would be the most heartening evidence that these professional groups mean what they say about free enterprise and American medicine. The salutary effect such actions would have on public opinion cannot be overestimated, even at a time when medical publicity is measured in millions.

What's in a Name? — Lots!

IN RECENT months several top hospital administrative positions have been announced in connection with which it is indicated that the administrator's title will be president or executive vice president of the hospital, instead of the customary administrator or director or the older term, superintendent.

Obviously, it is the job and the man or woman that count; the title is comparatively unimportant. Yet it is a fact that in our society generally, false values are often mistaken for real ones; we are inclined to show our respect for a president and ignore a mere superintendent, regardless of their real worth. More than it ever has been before, prestige in the community outside the hospital is necessary to the administrator's effectiveness today, when interpretation of the hospital's needs and services is such an important part of the job. Thus the hospital board that decides to give its chief executive a boost in title may be adding more than imaginary stature; it may be helping him get the whole job done the way it should be done.

Moreover, this practice will have a beneficial effect on the field as a whole. Community opinion of the vice president as a bigger man than the superintendent, administrator or director will tend to be reflected inside the hospital—on the staff and, in fact, on the board itself, again adding to executive effectiveness. Eventually, these opinions will be expressed in better salaries for hospital executives, and better people will be attracted to the field.

Of course, there are many hospital communities in which board members accept all the outward-looking responsibilities, and the executive's function is confined to internal management, or superintending. There are also many executives who are able managers but whose talent does not extend far outside the walls of the hospital. In these cases a change in title might be inappropriate. Wherever it is suitable, however, the new practice should be encouraged. It's a vice president's world, and we may as well face it.

Good Riddance

THE implications that a privately owned and operated hospital in a large American city had been operated as an abortion mill lurked behind a sensational murder and suicide mystery story that burned in the metropolitan press for a few days last month. Whether the implications were true or not, the incident underlines the need for adequate hospital licensure laws.

It is sometimes argued that it is the demand for abortions that creates such institutions, and that tight licensing regulations would only drive the abortionist and his patients farther underground, where conditions would be even worse. This is spurious reasoning. The abortionist and his patient are lawbreakers and moral outcasts whose needs and demands can have no consideration in our medical establishment. A hospital in which abortions are performed outside the law is not a safe place for anybody to get any kind of medical care. Proper licensing regulations, properly enforced, would make it impossible for such places to exist. The medical profession and the public would be better off as a result.

No Sense: No Cents

THE Murray Postal Bill (H.R. 2945) now before Congress doesn't make sense. In the long run, it won't make cents for the Post Office, either. The bill hits hard at magazines and weekly newspapers; it would increase the rate for second class printed matter on an average of 300 per cent. Such prohibitive rates could put many magazines out of business.

Democracy requires the free flow of ideas and information. This principle was understood well when our lawmakers established second class postal service. The fact was emphasized by an official of the National Association of Magazine Publishers who testified recently before the House Committee on Post Office and Civil Service. Referring to the Postal Act of 1879, he said: "The Act . . . recognized the principle that it is of great value to the country to provide for the widest possible dissemination of information of importance and interest to the people through our postal system."

In recent decades, as the cost of publishing has increased and the small newspaper or periodical has been squeezed from the scene, freedom of expression—insofar as the printed word is concerned—has been removed farther and farther from the common man. More and more, magazine publishing has become a privilege only within the reach of large sums of capital. Many periodicals serving science, the arts, the professions, and cultural or esthetic groups are able to keep in the field only because of help from voluntary membership organizations. The Murray Bill would seriously curtail many such official publications.

For most magazines, the price of the subscription is the lesser part of the total cost of production. A bigger and better publication is made possible through advertising revenues. The "paid space" brings the reader up-to-date information concerning the tools of his trade. Yet the Murray Bill would ignore this basic publishing fact and impose a sliding scale of postage increases based on the percentage of advertising.

Many educational and professional groups today recognize a need for federal aid to education and science. One way the federal government can be of service is to continue its present schedule of postal rates for periodicals that serve educational and scientific needs. The reports of the Hoover Commission give the impression that considerable economies might be effected through improvement in present post office procedures. It would seem prudent for the appropriate congressional groups to investigate all such possible economies in post office operation before legislating rate changes that would only make it harder for the Post Office to accomplish its purpose of aiding democracy.

SPEAKING OF AUXILIARIES

A MODERN HOSPITAL ROUND TABLE

GROWING importance is being given to the role of volunteers in our hospital planning. Right now, such auxiliaries are in the process of organizing on state and national levels. We should consider the advantages, also the disadvantages if there be any, of such organization. We should also weigh the benefits of greater auxiliary participation in our institutions because we have, unquestionably, a vast army of public spirited women who can become a powerful force in influencing public opinion on behalf of our voluntary hospital system.

Perhaps the greatest aid any auxiliary effort can render is in interpreting the problems of hospital work to the community. This is a public relations service and is quite aside from any specific project such as raising funds or supplying supplementary services.

The purpose of the discussion that follows was to consider how we can use the various capabilities of these groups to the best advantage, both locally and nationally, within and without our hospitals. What should be our first step in this direction, and where do we go from there?

The points of view of the auxiliaries themselves, the administrator and the hospital public relations director are presented in this forum which was held in the New York office of The MODERN HOSPITAL, with Raymond P. Sloan, editor, serving as chairman.

The participants included: Mrs. Kenneth C. Brownell, secretary, board of directors, Greenwich Hospital, Greenwich, Conn.; Mrs. Edward C. Delafield, honorary founding chairman, and chairman of fund raising, the Women's Society of the Memorial Hospital for Cancer and Allied Diseases, New York City; Mrs. Amos F. Dixon, president, New Jersey Association of Hospital Auxiliaries, chairman of the National Women's Auxiliary, member of the Council of Government Relations of the New Jersey Hospital Association, member of the Auxiliary Board of Newton Hospital, Newton, N.J.; Edith W. Johnson, director of public relations and volunteers, Mountainside Hospital, Montclair, N.J., and Dr. Madison B. Brown, executive vice president and medical director, Roosevelt Hospital, New York City. —THE EDITORS.

CHAIRMAN SLOAN: Because you are heading the organization program that is going on, Mrs. Dixon, won't you tell us what you think about state and national organizations of auxiliary workers?

MR. AMOS F. DIXON: Up until last September, when we went to the American Hospital Association's convention, most auxiliaries lived within themselves. When they met in Atlantic City, they found great value in comparing notes.

Because of that, and it was their choice, they felt that a great deal of value would come from organizing nationally. Since that time several auxiliaries have wanted to organize in local groups, state groups, and groups where they could get together and compare notes.

In New Jersey this year our main project has been to improve public relations, because we felt that while fund raising was the ultimate end of all auxiliaries, we had lost sight of the fact that if we could show our communities the great value of our hospitals, we would get more money and would develop more interest in hospital problems.

Therefore, we have had institutes and meetings that have been valuable in building up good public relations. Auxiliaries lost sight of that fact before, and now they are really trying to make public relations their No. 1 project.

MR. SLOAN: What progress is being made toward a national organization?

MRS. DIXON: They are preparing a program for the A.H.A. convention in Cleveland in September. They have organized a group — the committee that has been appointed by the board of trustees—and they are now developing a questionnaire so that we will

Mrs. Dixon* *...there should be a definite plan . . .*

know what all hospital auxiliaries are doing.

We want to send out a news letter about every six weeks, which will inform the auxiliaries what other auxiliaries in the country are doing. We are anxious to know which institutions have the best gift shops, as a source of information to others which may wish to start shops, and which want to know about merchandising, how to keep their accounts, and the value of gift shop operation.

Many hospitals have no auxiliaries. We plan to have books that will provide details on how to form an auxiliary, supply information about fund raising, and explain how one group can help another. Thus, if a project which is good in one hospital does not work in another, we can relay material to assist them. In other words, we want a clearinghouse of ideas.

MR. SLOAN: There is weakness in the organization of many auxiliaries, is there not?

MRS. DIXON: That is true.

DR. MADISON B. BROWN: The main difficulty is that these auxiliaries do not have a clarified purpose. Now if we start out with the premise that public relations is their main forte—

MR. SLOAN: Pardon me, are we agreed that public relations is their main forte?

MRS. EDWARD C. DELAFIELD: I agree. I know the Women's Society was founded on the basis of trying to inform the public about cancer and allied diseases.

EDITH W. JOHNSON: Do you think all auxiliaries have that as their main purpose?

MRS. KENNETH C. BROWNELL: No.

DR. BROWN: Not at all.

MRS. DIXON: If our auxiliaries are formed through a statewide organization, there should be a definite plan so they will know where they are going. They cannot just flounder around.

Also, the national organization should have a definite purpose and a definite plan, so that it will know where it is going, too.

DR. BROWN: It will have a variation according to the need of the institution.

Public relations embodies many things outside of the pure thought of printed matter. Many a time it is just word-of-mouth. It implies the interrelationships of the auxiliary with the hospital and the hospital with it. To borrow from industry, McCormick in Baltimore spends a great deal of time on public relations among its groups of personnel. It makes them realize they represent their company at all times. If we go abroad, we represent the United States. Everywhere you go, you represent your hospital. Therefore, your education must be sound in the strong points of your hospital to present it in the most favorable light.

WHERE IT CAN BE USEFUL

After the hospital auxiliary has been organized and given a purpose, then it really comes into a phase where it can be useful. There are many things that women are best qualified to do and assist the administration in doing. The weakness may be with administration at times in that it does not seek enough aid; then if the program is developed jointly, and the purpose is established jointly, with the channels of communication established jointly, a working organization exists and can create the prime purpose. And that prime purpose can be public relations or whatever is most needed in that particular hospital.

MR. SLOAN: Do you feel that by-laws are pretty weak in many auxiliaries?

DR. BROWN: In the several that I have examined, the majority of by-laws apply to a multitude of committees and appointments. What has disappointed me is the factor of determination or purpose of the organization. As Mrs. Dixon has said, you flounder a great deal if the by-laws lack organizational purpose.

MRS. BROWNELL: I should like to ask a question.

I am afraid, fundamentally, of policy that can stem from the board of trustees of the hospital, as well as from the auxiliary working with it. What is a volunteer in relation to the economic policy of the hospital? In bad times when the hospital needs volunteers its policy concerning them can change.

In a situation in which the hospital needs personnel but cannot pay for it, and in which a group of women would like to volunteer their services, what is your feeling, Dr. Brown, in having those people come in to take on professional duties? Should you pay them or should you not pay them?

DR. BROWN: Here we come close to one of the disadvantages of auxiliary groups within a hospital, that is, the danger that they may compete for what are supposed to be salaried positions.

AUGMENT HOSPITAL SERVICES

Logically and ultimately the voluntary groups are, as I understand it, to augment the services of the hospital. Financial necessity changes the elasticity of our thoughts. I would feel that, to the best of its ability, the hospital should attempt to find technically qualified people to fill all paid positions.

If I were short of cash, as we all are, I would then go to my auxiliary group and say: "Such-and-such needs more impetus; can you assist me?" It may have people who can do these jobs. If it then happens that I should pay them, they become employes of the hospital and are no longer volunteers. That, again, does not meet the problem, as far as I can see, except that assistance has been given in finding the proper employes for the positions.

Administration must use these auxiliaries to augment its services, and not put tongue in cheek and say, "Well, we can get them to do the work and eliminate some positions."

MRS. DELAFIELD: Dr. Brown, one of our objectives from the beginning in the Women's Society of Memorial Hospital was to try to augment established services or introduce new ones in the hope that if the latter turned out successfully and were recognized as having real value to the hospital, they would then be taken over by the hospital. That has happened with our recreational therapy department started by the Women's Society with Dr. Rusk's assistance. Once it was accepted and proved to be of real value, the hospital took over.

MR. SLOAN: In other words, you raised the money to inaugurate the project.

MRS. DELAFIELD: That's right; we sponsored it and raised some of the money to inaugurate it. It looks now as though our magazine, the *Memorial Review*, might be taken over by the hospital as its voice.

MR. SLOAN: What is the purpose of that magazine, Mrs. Delafield?

*Mrs. Amos F. Dixon of Newton, N.J., chairman of the National Women's Auxiliary.

MRS. DELAFIELD: We include in it articles by leading men in the field of cancer. We try to inform the public along every line. For example, in one issue Dr. Pratt told the problems of the hospital administrator, then the reasons why hospitals are so costly, particularly a cancer hospital. In one issue there was a long article on the opening of the James Ewing Hospital.

MR. SLOAN: What distribution does it have?

MRS. DELAFIELD: We started off by printing, on the first edition, 10,000 copies. We had to increase it to 25,000 copies. The same thing has happened on the second issue. It is the voice of Memorial and is the feature of our work of which we are proudest.

MISS JOHNSON: Whose names are on your list, your former patients?

MRS. DELAFIELD: No, it goes to all the members of the Women's Society and the board of managers and is sent out with letters of appeal. It is also sent to universities and to other hospitals and to large contributors. It is a great fund raising means.

WHAT ABOUT THE FRILLS?

MR. SLOAN: What about the frills which are not important enough to be taken over but which render a real and extra service to the patient? Are you prepared to continue with those?

MRS. DELAFIELD: Oh, yes, indeed we are. We are always in the position of not having enough jobs to fill the demand for work by volunteers.

MRS. DIXON: Well, you see that is the value, or one of the values, of a state organization and a national organization. We could refer a hospital that has difficulty getting volunteers to Mrs. Delafield. She could tell them what they could do to get volunteers and why she has so many.

MRS. DELAFIELD: You have to remember one thing. For a number of years, and all during the war, of course, there was a "volunteer department" at Memorial Hospital. For this we have always had a paid head. Often a volunteer slipped into the paid head category. Then there has also been, of course, the social service department, which was begun years ago and which has been functioning as a woman's auxiliary department. Our Women's Society overlaps into both groups. There are a good many members of the social service department who are also members of the society.

So, you see, we actually have three women's groups in the Memorial Hospital: (1) the social service; (2) the volunteer, and (3) the Women's Society.

The Women's Society produces volunteers for the volunteer department at its request. It produces volunteers for the thrift shop, for the social service department. There is overlapping along every line. That has been one of our great difficulties, to get geared.

MRS. DIXON: Overlapping may have value. Some hospitals have three groups, each with no idea of what the other groups are doing. They operate independently.

MR. SLOAN: Sometimes a social service group operates independently of the others.

MRS. DELAFIELD: Yes. That makes for difficulties in the beginning. I believe that every hospital should have a women's society. But when we first came into existence, with the attendant publicity, there was a tendency to ask: "Who are these women in the Women's Society? Why are they being made so much of?"

You see, we were new when the other women's groups, bless their hearts, had done such a whale of a job during the war.

We had quite a bit of adjusting to do.

MR. SLOAN: Do you have a paid director of your Women's Society?

MRS. DELAFIELD: No, that is all volunteer. We have an administrative board with a representative on the board of managers, just as the social service department has.

MRS. DIXON: When Mrs. Delafield mentions her representation on the board of managers, it reminds me of the meeting at Atlantic City. Were you there, Dr. Brown?

DR. BROWN: Yes.

MRS. DIXON: Delegates asked for a show of hands on the number of auxiliaries represented on hospital boards. They wanted to go back to their own auxiliaries and tell them about it, because many auxiliaries have no representation whatever on their boards.

ADMINISTRATORS ARE TOO BUSY

The women felt that if they were to build good public relations in their communities they must know more about the hospitals. Hospital administrators have been so busy that they have not been able to go out and talk to their communities or to talk to persons in their communities who, perhaps, might have grievances against their institutions.

Patients may come out of the hospital and say the food was not good. Food seldom seems good when you are sick. Under such circumstances small things are annoying. Therefore, the auxiliaries have lost track of the fact that it is one of their valuable contributions to be able to speak up for their hospitals. Because if there ever was anything that we are grateful for, it is a hospital that is near when we are ill and are not able to take care of ourselves.

Miss Johnson* *...the best way of selling the hospital . . .*

MR. SLOAN: When you say "representation on the board," do you mean as a trustee or as a board member ex officio?

MRS. DIXON: Either one. The president of the auxiliary or women's group should be permitted to sit in on the board to know what is going on. It is better to be there ex officio than not at all. Some hospitals have auxiliary members as members of the board, and it is extremely helpful if the administrator and the board work with the auxiliaries. It is of great value, if the women's auxiliaries are going to put through a real public relations program, for them to be informed about their hospital.

Perhaps the reason women have not been on the boards in some communities is because it is feared that they will go out and give the wrong impression. However, I cannot help but feel that the women are as interested in the hospital as anyone else—even if Dr. Brown does not stop laughing! I really think it is so. Dr. Brown, what do you say about that?

DR. BROWN: There should be women on hospital boards. Selection should be on the same plane as for any member; they are representative of the community and should not merely represent a definite group.

To come back to the problem of how you get liaison between the auxiliary group and the board, there are several tested methods. One is that the president is a member of the board, an

*Edith W. Johnson, director of public relations and volunteers, Mountainside Hospital, Montclair, N.J.

Mrs. Delafield* *...fund raising is in the back of everyone's mind . . .*

ex officio member, if you will. I think possibly that it is the better arrangement.

The other answer is to have a coordinating committee between the board of trustees and the auxiliary, so there is a complete threshing over of ideas. At times it may be difficult for a woman, if she is a member of the auxiliary group, also to be a full-fledged, full-hearted member of the board of trustees. There come times when you think one thing as a member of the board and something else as a member of an auxiliary. That may seem inconceivable to you, but that is probably one of the reasons why the men have, for so long, shied away from women [laughter] on boards!

I feel definitely that boards of trustees need—let us call it—the "woman's angle."

MISS JOHNSON: How can a woman's auxiliary function for the hospital unless the leader, at least in that group, knows what the hospital board of trustees is aiming for in the hospital program? If she is not a part of that planning group, how can she sell that program to her large auxiliary group?

DR. BROWN: I have sat through, in my short term, the progress from no women members to women members. I have also seen, in another institution, the struggle to gain representation. The struggle was highlighted because of the women going to Atlantic City. I feel that there is a place for them, and there must be that liaison.

The reason, perhaps, that I went all around the question and did not say outright that I feel firmly one way is because, as an administrator, I have to compromise between maybe a fast, hard-hitting group of men over here and a woman's group, which is so important to my success in the hospital. Maybe I will get them to come together. Possibly at first it is only going to be through a liaison or ex officio member, but later on they can be brought closer.

I have decided only one thing: That there should be a woman on the board, and that that woman, or women, should be representative of the community. It is conceivable that she is going to be from the women's auxiliary because she is within the field of interest of that hospital.

MRS. DIXON: It would be easier for you, in your work between your board and women's auxiliary, if the woman came from the auxiliary or had been chosen from that auxiliary. Isn't that so?

DR. BROWN: In the main, I think it is. At other times I think it is harder. We come now to a point where we have left a principle and perhaps come to personalities. At our board meetings we get into some things that just wash all around in a pool; this person, when she goes into the trustees' meeting, may have to listen to problems which, for a long time, are never transmitted to the women's group.

WHY TRUSTEES ARE RESERVED

That has been one of the factors that have made boards of trustees reserved. The good old man thought that he must be just as silent about all his problems as the Sphinx. It is natural, however, that if you have too big a burden you want to share it with someone—and that is the way a lot of things happen.

MRS. DIXON: I was interested in what you said about Atlantic City and the help that the women received there. I have had many, many letters telling about the great value of the Atlantic City meeting and how groups changed their whole organization when they went home. It had never occurred to me that being together with other women would be of such value.

MISS JOHNSON: Is the board of trustees at our hospital unusual in having the by-laws say that one-third of the membership must be women? Is that unusual?

MR. SLOAN: I would say it is most unusual.

DR. BROWN: It is almost unheard of. The usual thing is to have a board almost entirely of men or, sometimes, almost entirely of women.

MISS JOHNSON: Of course, we can select women board members much more easily than we can select men members because we have become acquainted through the women's auxiliary group.

MRS. BROWNELL: Isn't it true that the board of trustees of any hospital is responsible for the over-all functioning of that hospital?

MR. SLOAN: That is true.

MRS. BROWNELL: Therefore, they are responsible for the group known as the "women's auxiliary."

If you are going to give the responsibility to a group to do good for a hospital, it is up to the board to lend every possible help to that group in order that it may learn all there is to know about the hospital. Therefore, I think we can say to the board of trustees, "If we are to carry this burden of responsibility, you must let us be represented on the board which is responsible for the over-all organization."

MR. SLOAN: I think as time goes on, Mrs. Brownell, you are not going to encounter any difficulties. You must remember it is only within the past few years that women's activities have developed from the mending, caring for linen and the sewing circle stage to their present importance. It has been a very rapid development.

FEW WOMEN BOARD MEMBERS

MRS. BROWNELL: I did not realize how few boards of trustees have women members. I thought that all over the country women were represented on them.

MRS. DIXON: Oh, no! At Atlantic City we learned about that. And many are so proud that a woman from their auxiliary has graduated to the board since September that they have written to tell us about it.

MRS. DELAFIELD: The women's auxiliary president should really be a member of the board of trustees, because she is holding an important enough position for that. You were saying, Mrs. Dixon, that the women's auxiliaries should be talking about the hospitals in their communities. Of course, the community needs to be informed. I am wondering what methods we have for getting women informed. That is where our volunteers come in. We have a wonderful opportunity of informing a large group of volunteers about the hospital so that they can go out and tell the right story, a positive story about the hospital.

MRS. DIXON: You do a very good job of that in Mountainside, Miss Johnson. Your tours of the hospital, where you show what a hospital is doing and where money is needed, have been of great assistance. This group would be interested in learning about them.

*Mrs. Edward C. Delafield, honorary founding chairman, the Women's Society, Memorial Hospital for Cancer and Allied Diseases, New York City.

MISS JOHNSON: Our tour service is run by a special committee, the public relations committee of the women's auxiliary.

We are a much smaller hospital than is Memorial and have a much simpler organization. The chairman of our auxiliary is a member of the board of trustees. Then, under the women's auxiliary, we have various committees. One committee runs the volunteer services. The public relations committee has taken on, as its special function, this tour service. There are 16 members specially trained to take groups around the hospital. Tours are limited to eight or 10 persons who are told something about each department.

Many questions come up during the tour that the volunteer is not able to answer, but she saves these questions until she gets back and refers them to a professional person.

BEST WAY TO SELL HOSPITAL

We believe that actually seeing how a hospital is run is the best way of selling the institution. A patient sees only a small part of it. A well person gets a different slant. So we have been able to change the point of view of many persons by means of these tours.

MR. SLOAN: How do you get people to go on these tours, and who are they?

MISS JOHNSON: We usually have members of women's clubs, service clubs, and the like. This year we seem to be concentrating on girl scouts. The first few groups that came in were much interested, and we soon learned that they were going home and telling their parents and the rest of the family what they saw. This created interest among adult groups, and we got the adult groups in that way.

MRS. DIXON: You have men's organizations, too, don't you, such as the Rotary? I understand you have them for lunch.

MISS JOHNSON: Yes. We reach a large number of men through service groups. They come for lunch, but because of this awful problem of finance they pay for their meals.

Men's groups are very satisfactory to take through the hospital because, as business people, they are interested in how the institution runs. We hope that eventually we are going to reach all the people in our hospital area, and that they will have seen the hospital during the time they are well. I find that a person who has been through the hospital on a tour feels differently about it when he enters as a patient. Certainly our volunteers feel differently about being patients in the hospital.

MRS. BROWNELL: Dr. Brown, all of this points to the need for cooperation between administrator and volunteer groups. This is one of the things that the war pointed up tremendously: not only the headaches but the benefits that the administrators derived when they were faced with large volunteer groups. One interesting thing about volunteers in a hospital is that in the old days volunteers worked in hospitals in order to make them run. Isn't that so, Dr. Brown?

DR. BROWN: That is true.

MRS. BROWNELL: I was born at about the same time Greenwich Hospital was built. My mother and father, both doctors, started the hospital, so I was practically born on the steps. In its early days, had it not been for many women who took turns doing things, the hospital never could have existed. That held true for quite a few years until people realized that hospitals should pay for whatever services are rendered on the part of professionals, and we should substitute, as the chairman has pointed out—

MR. SLOAN: "Supplement" would be a better word.

MRS. BROWNELL: We should use the volunteer as a supplement. That may be one of the things that we have grown away from. Volunteers formerly did a great many things in the hospital that we would not dream of their doing today.

I think that our need—and maybe we are not alone in it—is that the people who need knowledge really need a profound knowledge of the hospital. A skimming knowledge does not do it. The administrator, his assistant, or someone should start with the A.B.C.'s of hospital administration and go right through, as you probably have done, Miss Johnson.

THEY SHOULD KNOW BETTER

We have so much misunderstanding on small things. For instance, I was asked whether I was paid as a member of the board of directors. Another question frequently asked, oftentimes by people who should know, is "Who pays the difference between the $5 payment of a ward patient and the cost?"

The correct answers, which comprise public relations to be sure, cannot be given in ten minutes. It really takes a course of education. That is the problem with which a great many hospitals are faced.

MRS. DIXON: Don't you feel they accomplish that at Mountainside by having a definite plan and being well schooled in what they want to tell their public?

MRS. BROWNELL: Wonderful! And that is done, is it, through heads of departments? Do you do that, Miss Johnson, when you start out? Is the education of each department done by the head of each department?

MISS JOHNSON: You mean as far as volunteers are concerned?

MRS. BROWNELL: Yes.

MISS JOHNSON: What you say about the administrator of a hospital is of prime importance: he must want to have volunteers. Then, in order to have a volunteer service function adequately, there must be a definite organization. Everyone must know, from the director down, where the volunteer comes into the picture, where her responsibility ends, and where the professional person's responsibility begins. The volunteer must know that, also; otherwise it just does not work.

For the last two years, we have been working on this principle, that a volunteer service in a hospital *is* a volunteer service, and the more it is run by volunteers the better. We have a director of volunteers and volunteer services because we have so many volunteers and they are doing so many different kinds of jobs.

MR. SLOAN: Do you mean a paid director?

MISS JOHNSON: Yes, a paid director of volunteers, someone to coordinate the work that is being done by these groups. Also, she is a professional person who represents the administration of the hospital. If the hospital were small enough, maybe the administrator himself could do it. However, I do not know of any hospital that would be small enough for that.

The volunteer service itself is run by the volunteer services committee, so we have a chairman who is responsible for all of the services. She is re-

Mrs. Brownell* *. . . more gray hairs are caused by the woman who wants pink satin . . .*

*Mrs. Kenneth C. Brownell, secretary, board of directors, Greenwich Hospital, Greenwich, Conn.

Dr. Brown* *. . . trustees need the woman's angle . . .*

sponsible to the director of volunteers. She has a placement chairman, who also does recruiting of volunteers, although we do not have to do too much recruiting because we seem to have volunteers feeding into us all the time.

Then, our different services are headed by chairmen, and the chairman of each service is responsible for volunteers in her service. She is responsible, in taking on a new volunteer, for seeing that she is trained, that she knows what her responsibilities are. The chairman of the volunteer services, the placement chairman, and the chairmen of the particular services are responsible to this new volunteer to see that she knows what the general rules of the volunteer services are and what the particular rules are in her department. They are also responsible for seeing that all volunteers become informed about the hospital itself, as well as about the particular job that each is doing.

MRS. DELAFIELD: We do it a little differently. We have a joint chairmanship. The chairman of the membership and what we call the "services" committee is one, because it is one department, you see.

We all bring in members, and whenever we find anybody who wants to do a special job, she is introduced to the chairman of that joint committee and given a questionnaire. We find out exactly what experience she has had, what she knows by way of work, such as with patients, or clerical work, or fund raising. We fill in a card for her with every bit of information, including what her husband does—because fund raising is always in the back of everyone's mind.

When we need an individual in any department we go straight to the chairman and we say, for example, that we need more guides, we need a guide who speaks Italian or Spanish or perhaps Russian. From her card file she will find the proper woman and produce her. It is a pool, in other words, and the volunteer works with the chairman of whatever department interests her.

MISS JOHNSON: Of course our setup is much smaller than yours, so it is simpler. However, all our volunteers are pooled. You have many more demands, different kinds of interesting things for volunteers to do.

MRS. DELAFIELD: I am not sure but what it is about the same. We have one situation that is entirely different from yours, though: we have to break down a reluctance on the part of the public to visit a cancer hospital. That is part of our educational problem.

MARK OF RECOGNITION

MISS JOHNSON: Mrs. Delafield spoke about enlarging the membership. Our by-laws now say that our membership is unlimited. We are choosing our auxiliary members from our volunteer group, so that we are choosing our members from a group of people whom we know to be already interested in the hospital. They also have given service to the hospital. It is a mark of recognition to be asked to become a member of the auxiliary.

MRS. DELAFIELD: Do you charge any dues?

MISS JOHNSON: We have $2 dues.

MRS. DELAFIELD: To cover the expenses of services we have a flat $5 membership dues, that is all.

MR. SLOAN: Your Women's Society was started only two years ago, wasn't it?

MRS. DELAFIELD: In the spring of 1946.

MR. SLOAN: And how many members have you today?

MRS. DELAFIELD: We have 600.

MRS. DIXON: You might be interested to know that in Newton we have a 45 bed hospital, and we have about 2300 members in our auxiliary.

MR. SLOAN: That includes the entire area?

MRS. DIXON: We have many little farming towns, and each group in its particular town comprises a little auxiliary of its own. Our board consists of the president of each auxiliary. They get members every year and work on their own project. The president goes to the board meeting every month and comes back to her group and tells what was done at the board meeting. Through having so many members we can build up the feeling toward our hospital and improve our public relations. They know what is going on.

MRS. BROWNELL: When you make up these little units which go to make up the big auxiliary, what do you say they are to do besides becoming educated?

MRS. DIXON: Up until the present time, or until last year, most auxiliaries were fund raisers. Therefore, the little communities raised money through square dances and all sorts of parties; they did many things to raise money for the hospital.

HAVE TO SAY SOMETHING

Having been one of the presidents, I can speak from experience. When we go to the board meeting, each president is called on to tell what she has done that month. When we stand up we want to say that we have done something, because the other folks have, and if we have not we feel just terrible. In fact, we wish we had stayed home. But then we have to make a report to our board or to our auxiliary when we go back; therefore, we have to be at the meeting.

MRS. BROWNELL: You are caught!

MRS. DIXON: We really have to get going. We have to do something during the month.

MRS. BROWNELL: Are you in a community chest?

MRS. DIXON: No, we have no community chest.

MRS. BROWNELL: There we bump into something else, again. Your fund raising for the hospital, if your hospital is a member of the community chest, consists only of the activity of the women's board or women's auxiliary, whatever it is called, for supplementary things. It might be an extra x-ray machine that the administrator has been hinting about for six months, something of that sort. That is how you raise money. Your hospital is a member, isn't it, Miss Johnson?

MISS JOHNSON: Yes, we are in the community chest.

MRS. BROWNELL: So you do not raise money on the outside. You would be shot at dawn, if you did.

MRS. DELAFIELD: Do you raise money?

MRS. BROWNELL: No, we do not.

MRS. DELAFIELD: You do, don't you, Dr. Brown?

DR. BROWN: Yes, we do.

MRS. BROWNELL: We raised funds for a new building.

MISS JOHNSON: The hospital that has to raise money has a certain advantage because there is nothing more tangible to work for than money, and women's groups, especially, are wonderful at doing that. I think the Newton group has done a wonderful job.

(Continued on Page 80.)

*Dr. Madison B. Brown, executive vice president and medical director, Roosevelt Hospital, New York City.

THEY'RE DOING BETTER AND BETTER AT BIXBY

ROBERT W. EVERETT

AT ITS superb best in our teaching hospitals and consulting rooms, American medical care today is widely acknowledged to be the finest the world has ever seen. As one foreign visitor studying American institutions observed not long ago, "Your best hospitals are better than anything we have in Europe. But our average is as good as yours," he went on, "because we have greater uniformity."

Whether this is true or not, most doctors and hospital administrators have long agreed that the big problem in American medical care is to improve the quality of crossroads, small town and back-of-the-yards medicine. This is one aim of the social planners who would bring all doctors and their patients into a gigantic medical grab-bag with the government holding the strings. It is equally the aim of other public and private groups having plans to funnel more money, men and materials into medical low-pressure areas. Vast plans and vast sums are generally assumed as essential to the improvement of medical facilities; yet the fact is that every community has within itself the resources for raising medical quality. Like the farmer who refused aid because, "I ain't farmin' now as good as I know how," most hospital staffs and boards need the inspiration and will to do better before they need outside money or plans.

STAFF AND BOARD WORK TOGETHER

How one hospital staff and board have worked together to improve hospital performance is told in the story of the Emma L. Bixby Hospital at Adrian, a community of 18,000 people in the southeastern corner of Michigan. Started nearly forty years ago with a $25,000 gift in memory of Mrs. Bixby, who had been a leading citizen of Adrian, the hospital is operated by a five-man board appointed by the city commissioners. Its seventy-eight beds are divided among three buildings—an old residence purchased and converted into a hospital with the Bixby gift in 1910, and two additions, the later one constructed less than ten years ago.

Unlike so many hospital boards whose members are selected largely for social tone and fiscal prospects, Bixby's present board was carefully chosen for what each man could contribute in special knowledge and managerial talent. Four members are businessmen or industrialists, and one is a professional man practicing in Adrian. Each board member interests himself and takes responsibility in a particular area of the hospital's operations, such as finance, personnel, plant or professional relations.

The interest of board members is more than perfunctory; at a recent meeting one member suddenly pulled out his watch and gasped audibly. "Say, when are you going to let us go home?" he asked the president. "This is the third meeting we've had this month," he added reproachfully. Normally, the board meets twice a month, the president explained to a visitor. "The meetings start at 8 o'clock in the evening and often last until midnight or later," he said.

Obviously, there is plenty for the board to talk about. At one meeting not long ago, board members outlined a program for the observance of National Hospital Day, studied plans for remodeling the central sterile supply room and discussed the cost of equipment to be installed, examined blueprints for a remodeled and refurnished nurses' home, reviewed problems attendant upon an impending change in radiology service and decided the hospital should seek a full-time radiologist, asked the superintendent about details of the handling of doctors' operating clothes and instruments, talked over possible rearrangement of locker-room space in the surgical department, and ruefully traded anecdotes developing from the fact that the hospital, at the suggestion of the staff, had recently ruled against offering out-patient laboratory service to patients not referred by staff members.

Every board member, it developed, had been stopped on the street by indignant citizens who interpreted the move as a deliberate affront to Adrian's osteopaths, whose patients at one time could have routine tests made at the hospital. Blistering "Letters to the Editor" had appeared in the Adrian *Daily Telegram* accusing the hospital of monopolistic practices, and worse, and some members of the board questioned whether it had been wise to stir up so much furore. After discussion on this point, however, it was agreed that the board owed the staff this support of its ruling. "We have asked the doctors to enforce higher standards all along the line," one board member stated, "so we can't very well back away from this request of the staff just because it has caused us some trouble."

NO SYSTEMATIC EVALUATION

The team spirit reflected in this comment has already accomplished a lot at the Bixby Hospital. At the time several of the present board members were appointed a year or so ago, it was apparent that the hospital had been going along for some years with individual members of the staff, board and administrative groups all doing their best but without any systematic effort aimed at critical evaluation of hospital performance, and without any organized attempt to raise and maintain standards.

The obvious need for an objective appraisal as a starting point for improvement suggested the employment of a consultant to study and report on

Wilma Senour, R.N. (right), the superintendent, and her assistant, Mrs. Murdy, in the reception office going over the patient suggestion slips. View of Emma L. Bixby Hospital, showing how it has grown since 1910.

all aspects of the hospital's operations. Eventually, a physician-consultant who is a nationally recognized authority in hospital administration was called in. Concurred in by the staff and board, his recommendations have guided all elements of the hospital organization in their efforts to provide better care for the community of Adrian.

Possibly the most significant of these recommendations had to do with professional organization. The loosely-knit staff was drawn together in a formal organization whose by-laws call for more careful selection of members, supervision and consultation, and regularly scheduled clinical conferences. The conferences are enlivened by the contributions of a pathologist who spends two full days a week at the hospital and is available for consultation at other times. This arrangement is comparatively recent and resulted from the reorganization that followed the survey.

As is the case in so many communities, the Bixby Hospital had long since grown past the point at which its former part-time, long-distance pathology service was adequate to the needs of the staff. This was a problem of time, distance and volume, rather than ability; a visiting pathologist came to the hospital, from some distance away, for a couple of hours once a month. As one doctor put it, "He only had time to walk past a row of jars." The expanded service gives physicians some of the help they need to practice medicine "as good as they know how."

Another common problem that existed at Adrian was the familiar one of medical records. With no organized checkup on performance, doctors had no strong incentive to keep histories, diagnoses and operative reports up to date. The condition of its medical records alone, as a matter of fact, would have prevented the hospital from obtaining one of its desired goals—full approval by the American College of Surgeons under the new point-rating system—though it has been "provisionally approved" for some time. As every hospital administrator knows, however, it takes more than a survey report to get medical records where they should be and keep them there. Staff-drafted rules approved by the board, with staff-sharpened teeth, are the only answer, and the staff at Bixby recognized this fact recently by suggesting a rule under which any doctor having five or more delinquent records will be denied hospital privileges for his patients until the records are brought up to date.

To help make this rule stick without working a hardship on doctors, a recent visitor to the hospital suggested that, while a hospital of this size did not necessarily need a full-time, registered medical record librarian, although this would be desirable, someone with other office duties might be selected for the short-course training in medical library responsibilities that is now available. It would help, too, it was pointed out, if the doctors had a medical stenographer or dictating machine to facilitate making surgical reports promptly following operations. The main factor in keeping adequate records and keeping them current, however, is notably present at Bixby Hospital today—recognition by staff members, board and administration that this is important and has to be done.

While staff performance unquestionably has most to do with the kind of hospital care a community gets, all the other elements have also been under critical review at Adrian, with many resulting changes designed to improve hospital tone. Many of the changes are aimed specifically at tighter control of the hospital's business operations, to make certain that patients' dollars will be spent for maximum safety and comfort for patients. One important step toward this goal, for example, was the recent installation of a bookkeeping machine.

Used initially for posting charges to patients' accounts, the machine will eventually replace manual pay roll, accounts payable and expense records. It has been recommended that when the cost accounting system is installed, it should follow the chart of hospital accounts that has been established by the American Hospital Association. In this way, it is pointed out, the hospital administration will be able to make direct comparisons of its operations with those of other hospitals, an obvious advantage.

Another recent step toward better business management at Bixby has been the reorganization of stores, inventory and purchasing procedures. Following a rearrangement of storeroom space, a complete inventory of supplies was undertaken and will be carried forward currently in the new system. When this is established and purchasing control is centralized, the

Left: Section of business office showing bookkeeping machine in use. Right: View of examining cubicle from nursery side. Limited space made it impossible to have a separate cubicle except by this means.

hospital's business methods will offer assurance that the patient's dollar is well spent.

At $15.68 a patient day, the cost of operating Bixby Hospital is high enough, in terms of what Adrian people earn, to make any unnecessary expense unthinkable. Even at that, however, Bixby offers a bargain. The average patient-day cost for Michigan hospitals was $14.83 in 1947, the last year for which an official figure is available. Taking into consideration known increases since that time, it seems likely that Bixby today is well under the average cost for the state as a whole. Examination of the pay roll, for example, supports the view that the operation is economical. With allowances for part-time help, the entire pay roll numbers a bare eighty people, or approximately one employe per bed, while hospitals of comparable size and service commonly have one and a half employes per bed.

Salaries are generally in line with those paid elsewhere in the state, where wages are definitely higher than in many other areas—a fact which accounts for Michigan's position as second highest state in the Union in terms of hospital costs. The hospital has recently inaugurated a training program for practical nurses which may offer possibilities for economies in nursing service later on. The present ratio of twenty-five graduate nurses to sixteen practical nurses, aides and students may be higher than is absolutely necessary; as practical nurses finish their training and become available for hospital duty, a careful analysis of nursing functions in the hospital may make it possible to economize in nursing costs without sacrificing nursing quality. This is one of a number of additional management improvements that are in prospect at Bixby and need only time and, in some cases, money to accomplish.

Adrian is happily free of one problem that haunts so many of the nation's voluntary hospitals—loss of needed revenue on patients who are public charges. A farm market and small manufacturing center, Adrian has few unemployed and a consequently small indigent population. The occasional hospital patient who can't pay his own bill is paid for by the county at regular hospital rates. Under a sensible arrangement that should be more widely adopted than it is, families having financial difficulties at the time a hospital bill has to be paid may get help from the county, then pay the county back as their circumstances improve. This system eliminates the troublesome problem of the "medically indigent" as far as the hospital is concerned. Even so, the hospital's credit losses crept upward in 1948 over the previous year, reflecting a trend that has been noticeable in hospitals all over the country and is thought by some to foreshadow generally worsening business conditions.

About 25 per cent of the patients coming to Bixby Hospital belong to Michigan Blue Cross, which pays the hospital its audited cost of $15.68 a day for these patients. The administrator, trustees and staff members all value Blue Cross and are interested in seeing it extended in the community.

Rates charged for services and accommodations at Bixby reflect the comparatively high costs of Michigan hospitals generally. The charge for a single room is $12 a day. A two-bed room costs $9.50 a day; the charge for patients in the hospital's four and six-bed wards is $8.50, and for pediatric beds it is $7.50. Other fees are in line with these prices: operating room charges vary from $14 to $18, with a special rate of $11 for tonsil and adenoid cases. Typical x-ray charges are $25 for a gastrointestinal series, $15 for chest, $16 for gallbladder. Laboratory charges are rendered according to a point system which results in a charge of $3 for urinalysis, $3 for blood sugar determination, and $5 for complete blood count. A separate charge is made for every medication given. The hospital stocks only standard drug items; prescription drugs are ordered from outside.

Like many another hospital that has to pay its own way out of operating revenues, Bixby must look to the community to keep its physical plant in shape. Gifts to the hospital in past years resulted in the accumulation of a modest fund out of which some recent minor plant improvements have been made. This fund, too, will pay for contemplated remodeling of the nurses' home, needed equipment for the central sterile supply room, and one or two other projects that are in prospect. These gifts, plus a small annual subsidy from the city, have made the community self-sustaining in its hospital care for the forty years since the hospital was founded with the gift of the Bixby family.

Left: Four-bed ward in new section. No segregation of race or color is practiced in the hospital. Right: This pleasant private room is also located in the new section of the hospital.

The number of beds seems adequate for today's needs, and there is no immediate likelihood of a sharp increase in demand for hospital facilities—a circumstance which makes Adrian more fortunate than hundreds of other communities. Yet the day will come when the old plant will have to be replaced. A quarter of the hospital's beds and the business, admitting and administrative offices are still located in the converted residence that was the original hospital in 1910. Its hand-carved woodwork and stained glass window give this part of the hospital a charm that few institutions enjoy, but eventually charm must be sacrificed to efficiency and economy.

Already the old building is more expensive to maintain than the rest of the hospital is, in quarters designed for other than hospital purposes, it is always costlier to provide the same quality of nursing and other hospital services. As the development of new technics puts increasing emphasis on the proper relationship of beds, corridors and utility space, the premium that must be paid to operate makeshift facilities grows.

Awareness of the fact that ultimately the community must build some new hospital facilities or suffer the consequences in costlier or inferior care is one reason Bixby board members, in common with hospital trustees everywhere, are increasingly concerned with public relations. Not long ago, the hospital board formulated and published a statement of hospital policies—an initial step in interpreting its functions to the community. The Hospital Day observance, which includes an invitation to the public to visit and inspect the hospital, is another step in the same direction, as is the board's declared policy of full publicity for all hospital activities.

Looking toward the goal of developing a closer liaison between the institution and the community it serves, the administration recently undertook to find out something about what Adrian thinks of its hospital. Discharged patients now are handed a printed form inviting their comments and criticisms. "Are you leaving the hospital satisfied?" the form asks. "Have you any suggestions that will help improve our service to others?" Other questions ask for comments on specific details of hospital service, and generous space is provided for any remarks or complaints the patient wants to make.

PAY ROLL AT THE EMMA L. BIXBY HOSPITAL
Adrian, Mich., 1949

CLASS	NUMBER EMPLOYED	AVERAGE MONTHLY SALARY
Supervisor	3	$285
Graduate nurse	25	250
Practical nurse	13	160
Nurse's aide	3	143
Orderly	2	185
Maid	14	100
Dietitian	1	300
Cook	2	105
Engineer	1	300
Janitor	3	165
Clerk	4	150
Technician	3	250

So far, the response indicates that Adrian's citizens are pretty well satisfied with Adrian's hospital. As might be expected, a few complaints have been made. "Sometimes some of the nurses are noisy after visiting hours," one patient wrote. "Some of your nurses are very good," said another, "but something should be done about the one that yells at patients." Investigation of this comment revealed that the patient was a woman who made so much noise in the labor and delivery room that the nurse had to raise her voice to make her instructions heard!

Most of the remarks, however, have been favorable. "Food excellent and tasty," one patient said, covering a point that is vital to most hospital patients and plagues most hospital administrators. Another comment underlines excellence in an area whose importance is fundamental but often overlooked: "Nurses are exceptionally cheerful, kind and sympathetic, qualities greatly appreciated by patients," this one stated.

Asked the same two questions—"Are you leaving the hospital satisfied?" and "Have you any suggestions that will help improve our service to others?"—a professional visitor who had studied the hospital's operations might well reply "yes" to the first. To the second question he might readily say, "Keep on as you are going, following through with the changes that have been initiated, never hesitating to make the other changes that suggest themselves from time to time. Above all, however, remain critical of your own results, and remember that no help from outside can ever give Adrian a better guarantee of adequate medical care than your own resolve to do 'as good as you know how.'"

FAMILY NIGHT AT MONTEFIORE

EUGENE D. ROSENFELD, M.D.
Assistant Director
Montefiore Hospital
New York City

MINNA FIELD
Social Service Executive
Montefiore Hospital
New York City

"TUESDAY Evening" at Montefiore has become a welcome and cordial invitation to the families of the hospital's ward patients. On this evening the house staff and social service staff mingle with relatives in a unique setting. They bring valuable and much-desired information with them to warm the hearts of any friends of the sick.

At Montefiore, we are continually looking for better ways and means of tapping the resources within our hospital and the community in an effort to create a more humane balance between scientific and social medicine. If this comprehensive medical program is to become a reality, the patient's family must be drawn from the background and brought forward to receive an increasing measure of consideration.

SPIRIT OF THE LAW OVERLOOKED

Until July 1948, our formal routine of family-medical staff relationship prescribed that at least one house staff member (intern, assistant resident, or resident) be present on each ward during visiting hours for the purpose of answering questions—if asked. The results satisfied the letter of this law but not its spirit.

The doctor got around to but few of the visitors and talked to them in Latin for the large part. Often he was called upon to discuss a patient with whom he was not familiar, the doctor responsible for the patient being busy elsewhere. The absence of sufficient secluded space on wards to conduct confidential discussions complicated the procedure, inhibited the inquiries, and restricted the doctor in his replies. The presence of patients often made frank discussion impossible. Patients frequently overheard fragments of opinions not meant for their ears—something to be guarded against at all times, especially during ward rounds and conferences.

The absence of trained social workers often handicapped the doctor or made time-consuming referrals necessary at a later date. But, more important still, the families of patients were disappointed. Many of them complained to the office of the director and, as a result, a new idea was born in the mind of a thoughtful and socially-minded intern, Dr. Stanley Bernstein.

At a house staff conference in July, the doctors were properly castigated by the administration for their apparent failure to satisfy the families' desire for information, when Dr. Bernstein suggested that the *entire staff* be required to meet the public for at least one hour weekly, and be released for other duty during visiting hours.

After some discussion, it was decided to open the Social Hall for this purpose (seating capacity, 200 people) at 6 p.m., Tuesday evenings for one hour. This time was chosen because it precedes one of the regular ward visiting periods. All members of the house staff, except those excused by emergencies, were required to be present. Individual doctors, representing their respective wards, are located at intervals throughout the hall. There are signs guiding visitors to the proper physicians. They are also greeted and directed by volunteers from the ladies' auxiliary.

Although as many as a dozen or more intimate and confidential conferences are in process at one time in various parts of the Social Hall, the very openness of the hall lends itself to quiet, calm discussion—the best type for acceptable results. Groups are sufficiently separated so that voices do not carry from one to the next, and those visitors who are waiting their turn do so in the back of the hall.

When the program began, the families were notified of the new arrangement by mail, through the social service department, information desk, on the wards by the nursing staff, and later by booklet (the information booklet for ward patients).

Soon after the sessions were instituted, the doctors became aware that many of the problems brought to them were of a medical-social rather than a purely medical nature. Working in a setting practicing "total" medicine, which considers the patient as a whole, the family of which he is part, and the community of which he is a member, it was natural for the doctors to welcome and encourage the presence of social workers during these sessions. As a result, Tuesday night joint sessions (doctors, social workers, families) were inaugurated on Aug. 18, 1948. With seven months' experience to draw on, we feel that we are ready to make at least a preliminary report on the experience.

VALUES TO FAMILY AND STAFF

What are the problems which the families bring to the doctor-social worker teams? What are the values accruing to the patients, family members and hospital staff? During the twenty-seven sessions since the inauguration of this service, a total of 1776 families has been seen, or an average of about sixty-six families per session. This means that at least one-seventh of the families of the ward population of the hospital have been seen at each session in this early part of our program. The numbers are increasing.

The problems they bring vary widely, determined by the nature of the patient's illness, the personality of the family member, the amount of anxiety they feel, and the pressure of social problems created by the patient's illness. Certain definite patterns emerge, however, and most of the problems can be classified into three categories: (a) those dealing with interpretation of medical infor-

mation, (b) problems in planning for the patient's discharge, and (c) problems in relation to the patient's adjustment to the hospital.

Of the three, the need to interpret medical information is the most frequently encountered, comprising 60 per cent of all problems. Hearing a medical diagnosis does little to allay the family's anxiety about the patient's condition. Oftentimes, the family members do not have sufficient knowledge to understand it.

Even when the name of the illness is familiar to them, they are likely to think of all the liabilities it connotes, and fear the worst. In other words, a medical diagnosis is likely to make them think of what the patient's incapacities are and to ignore what real potentialities he may still possess. And yet, even in a serious illness with a poor prognosis the patient can, with good medical care, maintain a certain level of usefulness to himself and the community. The presence of the social worker, who is able to interpret the doctor's information in social terms and point out what the patient can do in spite of his illness, gives the family members a varying measure of reassurance and stimulates their interest in planning for ways and means of creating for the patient a real place in the family group.

DIAGNOSIS MEANT DEATH

One such instance comes to mind. Mr. S., a 56 year old man, was admitted to the hospital suffering from cancer. To the family this diagnosis meant that death was inevitable and perhaps imminent. When the wife and son came on "Tuesday Evening," a month after the patient's admission, they were in such despair that they did not even have any questions to ask. The doctor began telling them of the treatment the patient was receiving, and the favorable way in which he was responding. It was more than the family expected. Overwhelmed by the news, all the son could say was, "Keep on talking, Doctor! I could just sit here and listen to you talk."

When the doctor finished, the social worker began a discussion of future planning for the patient. It then became apparent that what the doctor said meant only one thing to them—that the original diagnosis was wrong, and that their patient did not have cancer. Surely, a patient with cancer

could not improve to the point where discharge from the hospital could be considered, they argued. There was obvious need for further interpretation.

So that the family would not entertain any false hopes, it was important to convince it that the original diagnosis was correct. In order to protect the patient from unreal expectations, it was necessary to point up his limitations as well as his capacity. Toward the end of the interview, the family was able to see Mr. S. for what he was: a sick man with a poor prognosis who could not be expected to assume, upon discharge, the responsibilities he once carried; who would need care but who, within very definite limitations, could be expected to make a real contribution to his family.

Imminent or eventual discharge creates serious problems for patients and families, and we find that about one-fifth of our "Tuesday Evening" family interviews are concerned with this subject. By the time patients are admitted to our wards, the family, and frequently the patient, is reconciled to a prolonged stay. With modern means of therapy and our developing Home Care program, it frequently becomes possible to return the patient to his home. When confronted with this fact, the family often feels that the resumption of the burden of care is more than it can undertake.

For example, there was Mr. A., who was admitted to the hospital following a long period of illness at home, during which he was in great pain, requiring extensive care. His illness interfered with the family routine, robbed Mrs. A. of her sleep, and cut her off from outside contacts. After three months of hospitalization, the patient was ready for discharge.

Mrs. A.'s first reaction was that she could not undertake once again the type of care the patient needed. To allay her fears, the combined interpretation of the doctor and social worker was essential. The medical authority of the doctor, stressing the patient's improvement, the reassurance of the social worker, and the fact that the hospital was willing to help her carry the burden by providing the services of the Home Care program were all factors influencing her agreement to the plan for discharge, thus assuring the patient of a heartfelt, warm homecoming.

On the other hand, there are instances where the family members find it difficult to accept the fact that the patient needs continued hospitalization. For instance, Mrs. C., a domineering, demanding woman, had used her illness to dominate her children. In the hospital she continued to do so, spending visiting hours complaining to her daughter about the care she was receiving, and demanding to be taken home. It needed the combined help of the doctor and social worker to enable the daughter to withstand her demands. The doctor pointed out that the type of medical care the mother needed could be provided only in the hospital. The social worker helped by a discussion and sympathetic understanding of the problem facing the daughter. Fortified by this double reassurance, the daughter was able to stand the strain of the visiting hours without breaking down and acceding to the mother's demands.

GIVE VENT TO ANXIETY

Expression of dissatisfaction with hospital care is often the only way in which family members can give vent to their anxieties about the patient. In accepting such complaints at face value, the family frequently fortifies the patient's dissatisfaction. In fact, the third large group of problems deals with the difficulties the patient has in adjusting to hospitalization. Complaints about food, for instance, can often be taken care of by the doctor's explanation of the dietary requirements, while the social worker may help the relatives to understand the motivations underlying such complaints. In other words, this procedure provides an outlet for the expression of dissatisfactions in an atmosphere where a sympathetic handling of them is possible, in contrast to what frequently happens when complaints are made in the wrong quarter.

Last, but not least, is the support given to relatives when they are confronted by the patient's refusal to undergo recommended medical or surgical procedure, and insistance on signing out "against advice." Under

pressure from the patient, and without outside help, family members might be inclined to go along with the patient and remove him from the hospital, thus depriving him of vitally needed treatment. We have a number of instances on record where the authority of the doctor plus the sympathetic handling by the social worker resulted in family cooperation to the point where the patient was persuaded to undergo the necessary treatment.

The method of joint interview is not new. It was employed by the social workers in this hospital before "Tuesday Evening" was instituted. It was used whenever, in her contact with the family, the social worker felt that an interpretation of the medical information was indicated, or when she was confronted with a difficult discharge problem. In many instances, this meant a loss of time in trying to locate the doctor, who was busy with his other duties. "Tuesday Evening" eliminates such waste of time. Interdepartmental referrals are frequently made at this time without time-consuming conferences, consultations, telephone calls, or paper work, because the personnel necessary for such referrals is all present.

EVERYONE HAS A CHANCE

More significant than the mere conservation of time (which is considerable) are the many immeasurable benefits derived from this activity. First, much greater coverage—almost all visitors and members of the family are seen and spoken with. The physician finds that setting aside this particular hour saves him the distracting experience of being called hither and yon during visiting hours, and the dissatisfaction resulting from a hurried contact, with the knowledge that another distraught relative is hovering near by, anxiously awaiting his turn.

As part of the education of our house staff in social medicine, "Tuesday Evening" has been of great value. A much broader medical and social perspective is gained by the physician than would be otherwise possible. The family problems and their relations to the patient's illness become the focus of the discussion, and a clearer picture of the social, environmental and inherited factors in the patient's illness can be obtained. Unless better means of family contact are available, the doctors frequently are unable to obtain all the information needed for the proper care of the patient. Such information is frequently obtainable only from relatives or friends who cannot easily be reached, or who do not appear during the usual visiting hours. The time and energy expended in efforts to bring the two groups together are often self-defeating—and always out of proportion to the results gained. The doctors are able to talk scientific medicine where it does the most good, for battle against disease begins with the family.

Furthermore, this technic gives the office of the director an opportunity to witness the staff in action, to make suggestions, to correct laxity of approach or disinterest. It pays large dividends in public confidence and

support, cooperative families, and better planning. If a patient dies, the family's confidence has been won and consent for postmortem examinations is much easier to obtain. Our rate has gone up since this visiting technic began, despite an increasing turnover rate and a decrease in the average length of stay—factors which usually affect the postmortem rate adversely.

From the family's point of view, the advantages can be summarized as follows: Planning for the eventual care of the patient begins sooner, is easier to map out, and more effective. The family knows sooner what to expect. Will the patient come home? What facilities will be needed? What changes in mental attitudes must be encouraged? The family becomes a part of the over-all care of the patient. It is frequently possible to prepare the family, and through the family, the patient, for his eventual transfer to a different facility or to his home—or for a serious operation. The family can often be prepared for unfortunate or fatal prognosis in a gentle and sympathetic way, since both the doctor and the social worker are present and working as a team. The approach is direct, intimate, sympathetic and unhurried. Both staffs are committed to giving this time—nothing else need distract their attention.

The families get to know the doctors, and because knowing is usually liking, their confidence in the staff increases. Whereas, previously, dissatisfied and disgruntled family members often found their way to the office of the director (because the medical staff had so little time for them), these same families now have the feeling that they have been given special consideration, special attention. They have been won over. Many of the families have commented that these sessions save them many frantic calls in trying to locate the doctor or social worker, since they know that they will have an opportunity to raise all the questions they want. Their visiting hours, consequently, can be spent in actual visiting with the patients rather than in attempts to "catch the doctor on the run." Many of them, when told of the arrangement at the time of the patient's admission, comment "Why isn't this done in other hospitals?"

FAMILIES HAVE A RIGHT TO KNOW

Hospital executives will testify to the many families and friends of patients, who at one time or another have complained, often bitterly, of the difficulties encountered in obtaining a clear, concrete and sympathetic statement of the patient's problem from the house doctors, especially on the wards of a large hospital. Incoming inquiries by telephone are deliberately sidetracked before they reach the house doctor. Visiting hours, too, often find the doctor busy with new admissions, already engaged by other visitors, called for an emergency or, most frequently, not around—he's in the library studying, off duty, operating. The families of sick people have a right to know and we have an obligation to inform them of the patient's needs and prognosis. We must work with them in an effort to ameliorate the social and economic effects of disease upon the members of the household. This is particularly true where long-term illnesses develop. Technic must be worked out to give effect to these considerations, lest we come to deserve the frequent criticism leveled at many of our institutions—impersonal, cold, heartless.

Such criticism is impossible where the teamwork relationship, with its advantages to the doctor, the social worker, and the family, is combined in a single force standing ready to help the patient.

TOMORROW'S HOSPITAL

The Architect Says: "Could Be"

ROBERT W. CUTLER
Architect
Skidmore, Owings and Merrill
New York City

AMERICAN industry is world famous for its ability to produce in quantity and with uniform quality. Consider the articles which you frequently use; not all of them—perhaps 99 per cent—are produced by methods geared for mass production. Each procedure of the production line is analyzed for efficiency of operation. Time studies determine where lags occur. Costs are constantly checked. These facts, plus American knowledge, are the production manager's stock in trade. Can we apply these methods to the hospital of tomorrow?

As ivory tower planners we might envision a patient reclining in an air-conditioned, oxygen-supplied cubicle formed as a plastic egg moving on a belt line from station to station; from procedure to procedure. Incidentally, this is not altogether outside the realm of possibility, for recently in its book on contemporary hospital planning, a group of French architects incorporated a monorail which transported the patient through a series of rooms for preoperative and anesthesia procedures. Fantastic? Yes, but it has actually been put on paper, may now be in operation.

Lest we stray too far afield and overlook the problem at hand we had best descend from our ivory tower in the land of make-believe and deal in contemporary realism. The hospital administrator in one capacity is a plant manager; he is responsible to the board of trustees for the cohesive, efficient and economical operation of the various departments. The administrator should make it his business to investigate through time studies and flow diagrams, and use the plant manager's technic in his attempt to produce more efficient operation.

Naturally, our main concern must continue to be the care of the patient whom I would like to introduce to you as a man named "Pat." Fortunately for all of us responsible for the planning of tomorrow's hospital, the dissemination of knowledge about disease and the public's ability to accept preventive measures will have had a profound effect on how we care for Pat as a patient. He will strive to keep well but when sick will want to get well as quickly as possible. To assist him to the full we must understand Pat's emotional environment as well as his physical problems.

The ambulatory clinic will have taken on a new importance as a center for the over-all diagnostic survey of the patient while still on his feet. A realist, Pat will have insured himself and family against the time when one of them requires comprehensive medical care. Let us follow him through his hospital experience.

Those responsible for the ambulatory clinic have found that it is unnecessary to regiment patients in large waiting rooms like cattle. The atmosphere is informal yet efficient. Administratively it functions as any other business. Pat appears for his first appointment on time, goes directly to the assigned consultation room, is greeted by a physician whom he has never met. Upset, both emotionally and physically, Pat of course is not at ease, but the humane and personal interest of the physician soon reassures him. He is to return the following day for x-ray and laboratory procedures in the diagnostic clinic. Pat's physician will review the results with other physicians. This idea has appeal for back at the plant no one can make a major decision without consultation with his partners. To Pat, the world's most important decision is to be made—and in his behalf.

The diagnostic center has become the focal point of the ambulatory clinic. Pat's dressing room is pleasant, and there seems to be a sufficient number of these rooms. Apparently the planner has thoroughly investigated through time studies the flow from one procedure to another and has realistically incorporated the space conditions necessary to the proper function of each. The procedures are well timed, there is no lag, for time

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Presented at the American Hospital Association Institute on Hospital Planning, Washington, D.C., December 1948.

N.Y.U.-BELLEVUE MEDICAL CENTER, NEW YORK CITY

WILL IT BE A PRODUCTION LINE?

The Administrator Says: "Better Not Be"

SISTER MARY ANTONELLA
Sister of Charity of Nazareth
Administrator
Georgetown University Hospital
Washington, D.C.

HOSPITALS if they regard the individuality of their patients and their immortal souls can never lend themselves to a production line system of service.

The term "production line" and hospitals do not go well together. We have been accustomed to the use of this term in connection with the workings of industrial plants which produce various commodities — things. You and I have undoubtedly visited some such plants and in passing through the numerous departments have marveled at the variety of articles produced each day. The finished product also drew our attention as, after inspection, it was exhibited—a perfect piece of merchandise ready for the market. But however perfect, it was a *thing*.

NOT DEALING WITH PERSONS

Now this inanimate thing, the finished product, may stir the pride of the owner of the factory and to a lesser degree the pride of the numerous employes who made the parts. But they are dealing with things, not with persons, and the difference shows in the expression on their countenances. On more than one occasion when visiting one of these factories, this fact has made a lasting impression on me, namely, that the workers on these various parts of commodities seemed to be working without heart in a mechanical way with little or no interest in the part this, their work, was to play in the finished product. In fact, many employes today are performing works that are so mechanical that the playing of radios has become necessary to distract them from their humdrum duties.

Sewing buttons on a shirt eight hours a day, five days a week, four weeks a month, eleven months a year certainly ought to make for efficiency in sewing on buttons—but such pursuit can scarcely be expected to arouse the same enthusiasm in the worker as would the knowledge that she herself had designed, selected material, produced and marketed the product. In other words, to be purposeful, to be effective, to be acceptable, occupation must be motivated by ideals.

Along the assembly line one would seek in vain for the principles that animate hospital corridors; therefore, I repeat that hospitals if they regard the individuality of their patients and their immortal souls can never lend themselves to a production line system of service. The production line, however, as applied to industry has its advantages in the quantity produced, time saved, and great reduction of costs.

"Production line" in a hospital would likewise have its benefits, for (1) each department would, in the eyes of the public, become highly specialized; (2) costs of each division would be more easily obtainable; (3) nurses and attendants could follow a routine that would expedite business; (4) jobs would be created.

These and similar gains might be the result of the hospital's being so planned that it would operate on a production line, but the end product of a hospital is service to a sick individual—not to a thing. Even to consider such advantages is to forget that hospitals are dealing with individuals, with human beings who are endowed with immortal souls, and not with commodities. To plan our hospitals, for example, so as to have a department for the treatment of preoperative cases, a department for the treatment of postoperative cases, and a third, a department for the care of ambulatory patients, called the recuperative unit, where semi-hotel service would replace intensive nursing care, is to jeopardize the patient by retarding a quick restoration to health. Passing a patient from one department to another, much as industry passes on its products, is disturbing to him mentally.

To us who are in good health it may seem a slight matter to be moved from one place to another, to meet new faces, to adjust ourselves to surroundings, and yet let us pause for just a moment. Is it true that we consider it a small thing to make such adjustments? Facing the problem squarely, I think most of us would have to admit that it is difficult even for well people to make such changes in their lives.

EVERY CHANGE IS MAJOR

To the sick person every change is of major importance and presents difficulties that to him are insurmountable. Troubles that are not troubles at all when one is well become magnified and assume indescribable proportions when one is ill.

Each patient must be treated on an individual basis; his likes and dislikes must be studied and directed into channels that will help him not only physically but spiritually and mentally. What is very simple for one patient is quite complex for another. To say we can handle sick people according to a pattern termed "production line" is both un-American and un-Christian.

Every worker in the hospital field has had the experience with the sick who because of unavoidable circumstances have had to be moved from one room to another. We know how gently we had to break such news and with what tact we had to handle this particular problem so as not to upset them. Patients look for familiar faces among the nurses and other at-

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Presented at the American Hospital Association Institute on Hospital Planning, Washington, D.C., December 1948.

TOMORROW'S HOSPITAL:

ARCHITECT'S VIEW

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is important to Pat—he just can't afford to waste it. The efficiency impresses him, the tools are there to work with, his physicians and colleagues have a good chance properly to diagnose this thing that bothers him.

Pat inquires at the information center about the remainder of the ambulatory clinic. He learns that treatment is to be given on a definite appointed schedule, is to be private, and there will be no waiting if he cooperates. All therapeutic facilities are provided, and educational facilities are available to him. There are playrooms for the youngsters who have accompanied the mother and a perambulator station for the baby buggy. Here is planned all the equipment for these people to assist Pat back to health. He feels reassured.

ENVIRONMENTAL PROBLEMS ANALYZED

Pat's medical and environmental problems have been analyzed and diagnosed in the clinic; he is a desperately sick man. Because we have found that it is costly to intermingle the various types of service and stages of the illness of our patient we admit him to one of the single rooms of the concentrated nursing service. Each room has complete utility equipment, is engineered for air conditioning to be controlled as desired, is piped for oxygen, vacuum and pressure. Sound and visual equipment transmits Pat's image and his breathing to the master control center of the unit or units. Orientation of the unit and the amount of glass used are not important factors for Pat is a sick man and cannot appreciate the view. Time necessary to accomplish a procedure, efficiency of its operation, and assistance to the patient are the important factors.

These units of the concentrated nursing service are stacked one over the other for repetitive construction methods and more particularly to employ all the mechanical transportation systems for the conveyance of materials and supplies from central points within the stack to the units. Through time studies we have found that it is preferable to transport patient and supplies vertically rather than horizontally.

Pat requires surgery; he is admitted to a preoperative section for preparation, then into the operating room for his operation, and immediately into a reaction ward where special equipment and specially trained personnel administer to his needs before he is moved to the concentrated nursing service.

Authorities have always considered the operating department as a cul-de-sac or dead-end situation. Perhaps tomorrow's planning will consider it open at both ends for the mobility of stretcher cases through its length rather than in and out at the same point.

The ghost rears its ugly head and announces that it all sounds too heartless. We will have eliminated the personal feeling toward Pat. Well, we acknowledged that his care was the main problem at hand. Wasn't it mandatory that he get the most efficient, orderly care by specialized personnel without encumbrances or wasted time; wasn't it important that those serving him have every opportunity to concentrate on his well being?

Yes, and think of the emotional and physiological lift in store for Pat when he is moved, bed, linen and all, from the concentrated nursing service into the more leisurely confines of the convalescent service. He can choose a room, small, yet not unlike our hotel rooms of today. It has a low sill, one wall of glass, a balcony. He can enjoy the sun, view, air and complete life, of course within his physical limitations. Ambulatory again, he chats with his fellowmen in the commons room, admires Mother Nature from the roof deck. He eats in a central dining room, and in the evening enjoys a movie after dinner. Nursing care still continues but not on the highly specialized basis as he obtained during the critical stage of his illness.

As rehabilitation continues and the time arrives for his departure from the hospital, he wonders if other departments are as efficient as the clinic and nursing services. Pat investigates and finds that the community has had foresight to consider all its health facilities as one unit for the commonweal. The local hospital council has analyzed the community's needs to determine the feasibility of a central laundry, of group buying; it has investigated food handling methods, and other services.

This enlightenment resulted from the excellent work started in the late Thirties by New York City's hospital council, Detroit's federated program to finance the extension and modernization of its voluntary hospital system and its subsequent follow through, and the Rochester Regional Council's broad policy to assist both city and rural hospitals, and by many others.

PAT ENJOYS HIS FOOD

A man generally enjoys his food. Feeling himself again, Pat takes a keen interest in the roast beef, peas and baked potato which are served piping hot on the night before he goes home. His nurse explains the investigations and studies which the council had undertaken before arriving at the end result. These investigations disclosed that many hospitals had highly mechanized systems of food preparation; there was a conveyor belt in the kitchen where each article of the meal was placed on a patient's tray as it passed a service station. The tray was then transported vertically on a conveyor, removed at the designated floor, and given to the patient either individually, or from a truck. This mechanism had been subject to breakdowns at the most crucial times and depended altogether too much upon split-second timing on the part of the operating personnel.

Studies were made of a new industry, it was precooked frozen food. Each unit of vegetable or meat had been prepared and cooked immediately after harvesting, under the direction of skilled dietitians; had been hermetically sealed in a plastic bag then frozen. All the headaches of preparaton were accomplished elsewhere and to the strict specifications set down by the council.

Several days' supplies had been requisitioned from the central frozen food plant and stored in the pullman-like pantry adjacent to the dining room where our patient was then eating. Pat's dinner was warmed to the proper temperature on an electronic stove in a matter of seconds; it was a true personal service, this meal. He

was interested to learn that the entire service, tray and dishes, was to be thrown down the incinerator.

The local council had investigated and found that far too much time had been spent in handling the linen. Only those laundries were efficient in which the chute emptied directly into the sorting room adjacent to the laundry, and the machinery was planned and installed for proper step-by-step mechanized processing. These ideal conditions seldom existed for the laundry was so often located out in the field as part of the boiler plant.

New York City has extended a principle that has already been tested and found satisfactory on Welfare Island: the building of a laundry in each borough to serve the hospitals of that borough. Considerable saving of taxpayers' monies is evident. The council of Pat's community likewise instituted central procedures by enlarging the laundry and steam plant of its largest hospital to accommodate the laundry needs of the greater community.

There were howls—yes. Each hospital wanted control of its own linen, argued that trucking costs were high, and sorting problems insurmountable. But not for long, for sound business management soon had linens standardized: trucking costs were less than 2 per cent of the total laundry bill, and control was forgotten because deliveries were on time and in sufficient quantities.

Pat's nurse told him of the study and effort which had been consumed in the planning of the central sterile supply unit back in the Forties. The planners had attacked this problem deliberately and had actually used production line methods; it worked and worked well. At the moment the council was seriously considering a unit in the larger hospital to care for the needs of the greater community.

We are hesitant to try new methods; be guinea pigs for a new thought process. Schopenhauer wrote "Every man takes the limit of his own field of vision for the limits of the world." We who are responsible for the planning of hospitals must shed this stigma. We must be aware of broad implications that will eventually force us into action. This diatribe is not to be construed as a sales talk. It is more an attempt to stimulate discussion and imagination lest we become soft, stale and satisfied.

TOMORROW'S HOSPITAL: ADMINISTRATOR'S VIEW

(Continued From Page 57.)

tendants and not finding them feel lost. Once a sick person has become accustomed to his surroundings he does not like to be moved. Each change means a setback of some kind.

In these times the hospital days of the majority of patients are few in number. Surely if we consider the patient there is no advantage whatever in constantly giving him new surroundings with which he must become acquainted and to which he must become adjusted. And if we are not considering the patient, why have hospitals at all? The patient is the pivot around which all the activities of a hospital revolve; therefore, he must be considered first, last and always.

It will not be amiss here to cite a few examples: During World War I, when the flu epidemic broke out in camps throughout the country, nurse volunteers from hospitals were requested to take care of the boys in the various camps. Many were the stories that our Sister-nurses could relate when they returned from the army hospitals. The one, however, that was repeated over and over again and that seemed to have made a lasting impression on the minds of the Sisters was the one connected with the moving of soldiers from one ward to another as the illness became more acute. The pleadings of those boys that they be left with the nurses they had learned to trust and to love reechoed in the hearts of those same nurses.

Again, during the flood of 1937, in one of our hospitals in Louisville, Ky., where I was then stationed, two wards were improvised on the ground floor of the hospital. In these wards were the victims of the flood, many of whom had developed pneumonia or heavy colds; others were suffering from mental disorders caused by worry about loved ones. Our Sister-nurses took over these wards and while ministering to the bodies of the patients took great care to relieve their minds also in regard to their families from which they had become separated. These wards became sunshine spots in the hospital.

Finally, these patients were told that now there were beds in the hospital proper to which they would be moved and where they would have better accommodations. As each patient was approached on the subject, a look came into his eyes akin to fear. Better accommodations meant little or nothing to each of these flood victims, but the nurse-patient relationship that had developed created a bond of union that the sufferer was fearful of severing.

NURSE-PATIENT RELATIONSHIP

Whether we believe it or not, it is a truth that cannot be disputed that those who come to our hospitals for medical care look for more than just relief for the body. No matter what his creed, the sick person expects besides medical care a word that will elevate the spirit. To do this, then, we must know the patient, and a nurse cannot know the patient well enough to perform this spiritual work of mercy if the two never become acquainted. To pass the patient on from one nurse to another will destroy in our hospitals that sweet relationship that has ever existed between nurse and patient, a record which you do not find in the medical library of a hospital but a record which is kept in Heaven.

"Production line" in hospitals will lead to a lack of self-sacrifice in our nurses. They will become disinterested, fail to see the nobility of their work, and will soon look only to the monetary value of their task.

The nurse should be interested in the whole program that concerns her patient; much of the educational value will be lost if the nurse is to become interested only in one phase of the work. Her actions will become mechanical and I dare say that it would not take long before nursing would

cease to be classified as a profession. Nurses might then be qualified as good mechanics, but as nurses deserving of the name—never!

Loss of interest in the individual patient spells disaster to the nursing field. Nurse-patient relationship is built on the foundation stones of self-sacrifice, kindness and interest. These are services for which no patient can remunerate a nurse. I heard a patient make a remark once that I would like to repeat here: "I would rather lie sick in a barn and be treated kindly and with understanding than to lie in the most up-to-date hospital in the land where these virtues are wanting."

We hear so much today about psychosomatic medicine and its wonderful effects on the sick. Psychosomatic medicine is nothing new on the market in the nursing field. It has always been and will always be a powerful weapon in the hands of the nurse to fight mental disorders of one kind or another that retard the progress of the patient. This medicine, new in name but old in fact, is always used by the competent, tactful and faithful nurse, for she knows that to cure the ills of the body, the ills of the mind must be first relieved. Psychosomatic medicine will lose its efficacy in a hospital where nurse-patient relationship is destroyed by a production line.

COST AND LOSS

This article would not be complete if the discussion of cost and loss were to be omitted. "Cost and loss" seems a more appropriate term for hospitals at large than does "profit and loss" which is used in industry, for hospitals do not realize a profit. To those who are familiar with the activities of a hospital, I need say little about cost and loss for this is one of the daily problems of any administrator.

Hospitals that are planned according to the production line pattern will necessarily have an increase of cost and loss owing to several factors: (1) Construction costs will be increased because of space required to put such a program into effect. To segregate the various stages of cases in a hospital means more rooms for patients, more rooms for services rendered, more equipment. (2) More personnel will be required in the nursing service, the housekeeping service and the business office. (3) An increased circulation of various kinds of supplies will be necessary. (4) The laundry and central linen service will have a heavier load to control.

These are some of the costs and losses that "production line" will bring to those hospitals that adopt such a procedure. The greatest of all losses, however, will be the loss of the good will of the patient. Hospital life is strange at best to any patient; therefore we should work to put him at ease when he enters our hospitals. The same kind hands that prepare him either for the operating room or for some treatment are the same kind hands he looks for when coming from under the anesthetic or when returned to "his room" as he loves to call it.

THE NURSE'S AMBITION

In the heart of every good nurse there is this desire, this ambition—to receive the patient kindly, to dispel his fears as to what he may encounter in a hospital, to ease his pains to the utmost of her ability, to provoke the smile and the laugh from her patient so as to raise his fallen spirits, to say the word that will reach the immortal soul so that the patient may leave the hospital better not only physically but spiritually as well, to follow up her patient day after day until it is her pleasure to prepare him for that great event—going home. With a smile and a handshake the nurse bids her patient Godspeed and there is now a relationship between nurse and patient the value of which only God can estimate.

ADMINISTRATIVE CAPSULES

HOSPITALS DIFFER from commerce and industry in another essential respect. Waste in the hospital is excusable within reasonable limits where human life and comfort are involved.

THERE ARE TWO ASPECTS of a doctor's work: (a) medical and (b) social. For the medical aspect he most often gets a fee from his patient. For the social aspect he must be subsidized by the community. Since we need both, we must seek a way of solving this vexing economic relationship between doctors and their patients generally.

EVERY HOSPITAL, no matter where it is located, or by whom conducted, is a laboratory for the study of social medicine.

IT IS A MISTAKE to permit the first-year medical student to dissect a cadaver in order to enable him to learn anatomy without giving him biographical material about his subject to teach him the social as well as the medical lesson.

WHAT THE HOSPITAL is expected to do on an individual basis for psychosomatic medicine it should do on a collective basis for social medicine since social medicine is, after all, a combination of psychosomatic principles applied to groups of individuals.

HOSPITAL CARE is not limited to the hospital proper. It can be administered outside of the hospital with equal success more inexpensively and more acceptably to the patient through an extramural program which penetrates the walls of the hospital to a considerable distance beyond.

HOSPITALS SHOULD, of course, keep a record of rejectees and analyze them for communal purposes. However, an inspection of "chronic" hospitals, homes for the incurable, county hospitals, almshouses, poor farms, homes for the aged, and the like will reveal a number of such rejectees whose claim on the general hospital is indisputable.

E. M. BLUESTONE, M.D.

THE LATEST THING IN HEALTH BILLS

has approval of hospital and medical leaders

FOLLOWING introduction of the Voluntary Health Insurance Bill in the U.S. Senate on March 30, hospital groups moved to support this proposed new federal program to provide aid for indigents by furnishing financial assistance enabling them to enroll in voluntary hospitalization and medical care prepayment plans.

American Hospital Association support for the bill was assured when Joseph G. Norby, president of the association, wrote to fifty national hospital leaders stating that the proposed legislation appeared to be "basically in agreement with the program endorsed and advocated by the American Hospital Association."

The bill embodies the most important features of a program initially proposed publicly by Dr. Gilson C. Engel of Philadelphia, president of the State Medical Society of Pennsylvania; the plan was first presented to the hospital field in The MODERN HOSPITAL for March 1949, in an article by E. A. van Steenwyk, director of Philadelphia Blue Cross, who assisted Dr. Engel in developing the important prepayment features of the program.

Dr. Engel first conferred with Sen. Lister Hill of Alabama, who sponsored the present bill, last January and reported that Senator Hill was "definitely interested" and would work toward putting the program in proper form for legislative consideration. In the conferences that ensued, officials of the American Hospital Association and Blue Cross and Blue Shield commissions aided in preparation of the legislation. Earlier, Dr. George F. Lull, general manager of the American Medical Association, had indicated informally that the association approved of the program, although some modification of the prepayment feature as originally proposed by Dr. Engel was suggested by A.M.A. officers.

Mr. Norby's letter made it clear that the bill would be fully supported by the American Hospital Association. "Your officers feel that this proposed legislation merits endorsement in principle by hospitals and the association," he stated. "It provides a means whereby voluntary effort and government may work together more effectively to improve and extend the hospital and health services of the people."

An editorial in the *Journal of the American Medical Association* for April 9 states that the measure "is a type of legislation that corresponds with the principles of the 12 point program which have been urged by the American Medical Association for some years."

The bill, which was sponsored jointly by Senator Hill and Senators O'Conor of Maryland (D.), Withers of Kentucky (D.), Aiken of Vermont (R.) and Morse of Oregon (R.), is in the form of an amendment to the Public Health Service Act of 1944 and is described as "A bill to authorize grants to enable the states to survey, coordinate, supplement and strengthen their existing health resources so that hospital and medical care may be obtained by all persons." The program would be administered by the surgeon general of the Public Health Service, with the assistance of a federal hospital and medical care council.

Patterned after the successful states-aid program established in Public Law 725, the voluntary health insurance bill would provide funds to be administered through regional hospital and medical care authorities established by the states for the purpose of (1) providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care; (2) stimulating voluntary enrollment in prepayment plans for hospital and medical care, and (3) strengthening and coordinating existing health resources.

Under a formula similar to that established in Public Law 725, the purpose of which is to make higher percentages of federal funds available to states with the lower per capita incomes, federal funds would be provided to pay for hospital and medical care of indigents, using local nonprofit voluntary prepayment plans. Persons who qualified for aid through the hospital and medical care authorities would be provided with regular subscription memberships in the appropriate Blue Cross and Blue Shield plans, it was explained, so that they could never be singled out as "charity cases" at the time service is required.

The bill stipulates that regulations governing administration of the program would be promulgated by the surgeon general, with the assistance of the federal hospital and medical council, within six months after enactment of the legislation. In general, the regulations would cover standards of eligibility of persons requiring aid, types of hospital and medical care to be provided, and standards for participation of voluntary prepayment plans.

Additional provisions of the bill would furnish aid to stimulate enrollment of the population in prepayment plans, emphasizing employer participation in payment of subscription charges and enrollment of rural populations. A specific provision of the bill would make salary deductions possible for payment of prepayment plan membership charges for federal employes.

The bill provides that membership of the federal hospital and medical care council shall include two physicians, two hospital administrators, two prepayment plan executives and four consumer representatives. Still another stipulation of the bill makes provision for state surveys of existing diagnostic facilities, facilities and services for the care of mental, tuberculous and chronic disease patients, areas unable to attract and maintain physicians in private practice, and existing enrollments in voluntary prepayment plans.

In his statement to the Senate introducing the bill, Senator Hill said that its purpose was to "perform the

same service for financing hospital and medical care that the Hill-Burton Act is now doing in the building of new hospitals." A compulsory system of health insurance carries the danger of uprooting and destroying the entire system of medical practice, Senator Hill said. "We believe the present system has been too valuable and too effective and too useful through the years to throw it aside for a new system which might not work," he stated. "We believe it is the course of wisdom first to examine existing health and hospital and medical resources, then to proceed with the building and strengthening of them where necessary to bring adequate health care to all the people."

Senator Hill stressed the importance of avoiding the identification of medical aid recipients as "charity patients," stating that this was one of the principal advantages of the program. He also pointed out the advantage of administering the aid plan through existing prepayment agencies. "It seems reasonable that where individuals could not afford all the annual subscription charge, they might be able to pay part of it, with government assistance for the remainder, and feel that they have contributed to their own protection within their own financial limits," he stated. "It is important that we maintain this sense of responsibility.

"In its broadest effect the bill will stimulate the coordination and full use of the nation's health resources. Under it, the federal government gives financial aid, encouragement and wise guidance from its vast resources, its broad experience and its facilities for technical study and research. Yet control and administration of the program rest with the states and their communities, adapted to local needs and conditions. Finally and most important, our steps to extend adequate hospital and medical care to all the people preserve at the same time the fundamental freedoms, the incentives and the individual personal relationships which have done so much to give America the highest quality of medical care in the world."

Some opposition to the bill was anticipated from medical groups which have opposed expansion of Blue Cross. The original proposals by Dr. Engel were sharply criticized in an editorial appearing in the March issue of *Northwest Medicine*, official journal of the state medical societies of Oregon, Washington, Idaho and Alaska. "As a program, the ten points [as originally proposed by Dr. Engel] are so impractical in many respects, so idealistic and socialistic—in short, such a sitting duck for bureaucrats, that they might well have been written by [Federal Security Administrator] Ewing," this statement said. "The saddest commentary lies in the fact that some thirty-eight state [medical society] presidents fell for the thing. For our part we want none of either the program or its manner of development and presentation."

Opposition to the bill was also expressed by groups favoring the administration's national compulsory health insurance program. Spokesmen for these groups generally expressed the opinion that the voluntary approach would fall far short of meeting the nation's health needs; one writer, wide of the mark, described the Hill bill as a "flanking movement" by the A.M.A. in its fight against compulsory health insurance.

Whether the bill could develop enough support to overcome opposition from both extremes remained in doubt as it moved into the legislative machinery for processing last month. Its chief lack, in the opinion of many observers, was political *schmaltz*. Its very reasonableness was a handicap, some thought; the moderate approach through existing agencies offered little to excite the voters, who still like to argue, one way or another, about pie in the sky.

Setting Up the Disabled

SETTING Up the Disabled" is the subject of an interesting article by C. B. Heald in the Feb. 5, 1949, issue of the *Lancet* (England). The author has used the term "setting up" rather than rehabilitation since the latter implies that the patient will return to his former state of occupation. This is not necessarily so, and "setting up" is used to denote the fact that the patient must be trained for a new type of work.

A high relapse rate with resultant waste of beds, effort and money, and one of the reasons for interest in setting up the disabled, is often due to haphazard occupational therapy and an unrealistic view towards the patient's future. Housing, family and financial difficulties are additional factors in a high relapse rate.

Among the agencies to help the disabled, the writer reports, are the Government Re-employ factories, and village settlement schemes, such as the celebrated Papworth Village. The latter are the best choice for tuberculous or infectious patients. The Re-employ factories are mainly for ambulant and semiambulant patients. The homebound patients present the greatest difficulty. The environment and social factors of the home are of paramount importance.

The plan the author offers for setting up patients is a setting up center staffed by specialists to take care of three types of patients:

1. Those who could return to their former work in from three to six weeks.

2. Those who need training for work different from the kind they did formerly (candidates for Re-employ factories).

3. Those patients who will be homebound.

The center would need a convalescent section, a hardening-off section, a section for training the homebound, and, in addition, a physical medicine department and an educational and industrial psychology department. All of these sections would be coordinated with the parent general hospital.

Not only must the scheme ensure a market for the work of the homebound, but it must also ensure him a home in which to work. In this scheme, the author continues, the center would watch over a settlement of widely dispersed cottages planted where conditions were most favorable from the point of view of marketing and supervision, preferably in the neighborhood of Re-employ factories.

Dr. Heald concludes that setting up calls for skilled study of the total patient. He must be given security and should not be inculcated with the idea that he must return to his former state. If setting up is properly used it should reduce the relapse rate, provide continuous care for the patient, and speed up turnover.—I. GOTTSEGEN.

BY PAYING LESS WE PAY MORE

The author views low wage scales with the suspicion that perhaps they are not so low, budgetwise, and his experience has proved him correct

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I HAVE often been asked how hospitals manage to obtain employes for lower salaries than are paid for similar work by industry and business, especially during periods when jobs are plentiful and labor is scarce. The question is an embarrassing one and not easy to answer. As is always the case, when the answer is not clear there is usually not one answer but many.

We employ (put up with is the term often used) some workers who cannot find work elsewhere because of limitations, physical or otherwise. Many of our jobs have no parallels in business or industry. We offer greater stability of employment—our jobs are not seasonal and we are less likely to discharge employes during short or even long periods of economic depressions. Some of our employes stay on because of their desire to aid in our philanthropic purpose.

THERE IS A BETTER ANSWER

All of these reasons have some validity and I am sure many, many more can be and are given, which have equal or greater validity. But do they really answer the question? I think they do for a portion of our employes and for certain hospitals. What about the remainder of our employes? How do we manage to pay them less than other employers do and still manage to hold on to them?

For me the answer became clear when I began to think, not in terms of hospital departments, nurses and clerks, but rather in terms of accepted economic principles. A widely accepted economic principle is that when freed of restrictions, labor, as well as capital, tends to flow to those areas and enterprises where the rate is highest. Why then, should employes take less for a given amount of work than they are offered elsewhere? Does the common hospital experience violate and tend to disprove the accepted economic theory loss? The answer is, "no."

The fact is that the hospital must, and in the long run does, pay the same amount of money for a given quantity of work as do other employers. Note that I have not said that the hospital pays its employes the same hourly rate as business and industry do although in some cases we do. I have merely maintained that we pay the same amount for a given quantity of work.

If my assertion is true, which is to say, if we are to accept established economic principles, it follows that if we pay the same amount for a given quantity of work as do other employers and if at the same time we pay a lower hourly rate to the workers, then we must be spreading that amount of work among more workers. Put in another way, when we underpay our employes we are hiring more men for the job than are necessary, at a lower wage per man. When we practice that sort of economy we receive even less for our dollar, for then we begin to pay for the cost of frequent turnover, for low productivity during training periods and for excessive waste which is an inevitable by-product of low morale.

Reasoning along these lines we began to search for areas in our hospital where an apparently low comparative wage scale might constitute in fact an overpayment and a loss. We considered, first, a category for which a parallel exists in both industry and business—the secretary. To accomplish a particular type of secretarial task we employed nine secretaries. Each occupied a small office widely separated from the rest. The pay scale for these clerks was from 60 to 70 per cent of the average scale in business.

A study proved that there were periods for each when there was no work and that there were peak periods for each when the work could not be handled properly. Since the offices were widely dispersed the work could not be divided during peak periods even though one clerk's peak load might correspond to a period of enforced idleness for another. Furthermore, the work during peak loads could not always be postponed to await the slack periods. Thus during the peak periods the overwork was hastily and often badly done. As is often the case, enforced idleness tends to lower the morale with an attending reduction in the quality as well as the quantity of work.

TOO MANY EMPLOYES

We had here then a case of spreading the work unit over too many employes with the expected results. The correction was apparent. We grouped the secretaries into a single suite of offices. We reduced their number from nine to five and the half-time services of a sixth and we were able to increase their salaries to the level where we could compete on equal terms with other employers. The total salaries to the new higher paid group are less than the total of low scale salaries paid before. The results became apparent almost immediately; the morale is high and the work vastly improved.

The next category we considered was that of housekeeping employes—porters and maids. Here, too, the scale was lower than that paid in business. Ours is a pavilion type of hospital and the housekeeping was organized vertically by pavilions, each under its own head housekeeper. The quality of work was uneven—better in some pavilions than in others. The quantity

of work per employe varied from building to building.

Cleaning methods varied considerably. The same type of floor was cleaned by at least four different technics, each housekeeper being convinced that her method was best. An unnecessarily large number of cleaning materials items had to be purchased and kept in stock. It was difficult to assign personnel from one pavilion to substitute in another pavilion where it might be badly needed because of unusual absenteeism or vacancies, or in special situations because each housekeeper was concerned only with her own area.

While the proof of overemployment here was not as evident as with the secretaries we were convinced that it was so. A study of the pavilion where the work quantity was greatest convinced us that the porters were not being overburdened, which meant that the men and women in the other pavilions were doing less than a full day's work. The correction here, too, was not difficult. An expert executive housekeeper was employed and made responsible for all housekeeping. After a short period she was able to reduce the number of employes. Further economies were effected by the installation of uniform methods and by a decrease in the number and quantities of cleaning materials. A new schedule which introduced night service for those areas not used at night (OPD, radiotherapy, library and laboratories) promises further economies because the porter is no longer interrupted by the functional activities of the department.

In a third department which we studied (ward orderlies) we applied the horizontal organizational control with equal effect. Here, too, was a low paid category. Here, too, the control was vertical by pavilions. The service was uneven and it was difficult to shift the personnel to cover for absence and special situations. An experienced chief orderly was employed and made responsible for all orderly services in the hospital.

TURNOVER REDUCED

In addition to installing an effective training program he was able to use orderlies from areas where the work was lighter or temporarily reduced by low census as substitutes for absentees. Thus, whereas it was necessary before to pay for eight hours of overtime whenever an orderly was absent (and I am sorry to have to admit that our orderlies were absent just as frequently as yours and possibly for much the same reasons) now we can often provide the same service with no overtime or less overtime pay. The resulting saving was a factor in the decision to raise the scale for orderlies. The pay raise and better organization were certainly factors in the lower rate of turnover and higher morale.

What I have described above is by no means unusual. Competent administrators the country over have done more, and certainly we at our hospital have a lot more to do. But the principle is most important. We must view low wage scales in our hospitals with suspicion — with the suspicion that they may not be low at all; that budgetwise they may indeed be high and costly. Such suspicion is constructive and will, if followed by study and action, make less frequent the necessity to answer the query with which these remarks were begun.

Center of Health Service

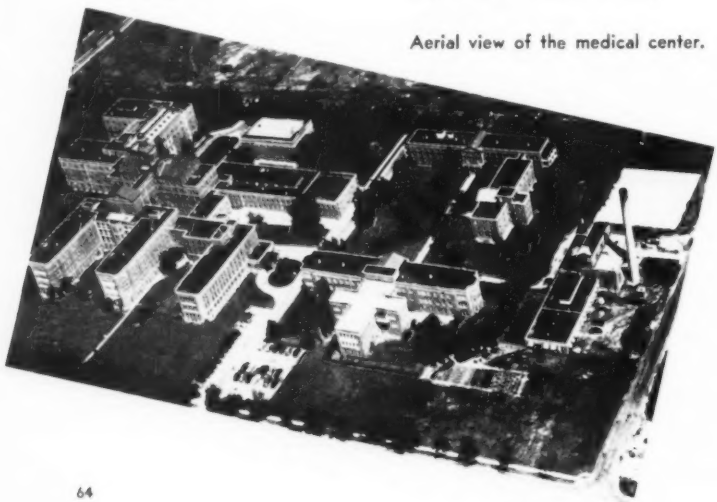
PLANS for expansion at the University of Colorado Medical Center in Denver are aimed at "paving the way for concentrating all university activities having to do with health science services at the Medical Center," according to Dr. Ward Darley, executive dean of the center.

Expansion in the building program at the center includes plans for construction of a $588,000 cancer research building and the addition of a fourth floor to the east wing of the center to accommodate expansion of the maternity ward and nurseries.

Construction of a utility building also is under consideration. The proposed building would house a paint shop, garage, carpenter shop, and gymnasium, and would be constructed at an estimated cost of $160,000. General remodeling is being carried out throughout the buildings in order to accommodate more office and laboratory space.

"In planning the cancer research building, we have attempted to make provision which would directly and indirectly relieve certain unfavorable conditions in the medical center," Dr. Darley said. Preliminary planning has been completed and approved by the cancer institute engineers. Two full floors of the building will house the cancer research and also will accommodate the Damon Runyon Laboratory of Chemical Embryology. A grant of $25,000 has been received from the Damon Runyon Cancer Fund for establishment of this laboratory.

Dr. Darley said it is hoped the administrative reorganization at the center will eventually make possible the operation of a school of public health and a school of dentistry. The medical center may someday house the college of pharmacy and a separate school of nursing with its own dean and independent administrative setup.



Aerial view of the medical center.

WHAT ARE YOU GOING TO DO ABOUT IT?

if the federal government engulfs the voluntary hospitals, the hospitals can blame their own apathy

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THIS is an article of exhortation and prayer, and I start it with the frank admission that it would be preferable to have it come from another source. My professional interest is public relations—particularly public relations for hospitals and health agencies—and I have things to say in this connection that might be in better taste if uttered by someone more objective.

But I am tired of grinding my teeth in futility and helplessness while the propaganda mills at Washington roll relentlessly on. I am alarmed at the crumbling of the foundations beneath our essential freedoms. The things we value most dearly are slipping away from us, and our resistance to their loss is so slight that it scarcely merits or receives recognition.

Specifically, I refer to the concept which holds that an increasingly powerful federal state is necessary to solve most of our problems, a concept of which compulsory health insurance is perhaps the most overwhelming peace-time product to date.

UNWHOLESOME CONDITION

In the light of world events during the last two decades, we should require no great vision to convince us that such a state is unwholesome. We should know that it never returns as much as it takes away. We should know that in it the individual—whether person or hospital or community—must unavoidably become as meaningless as a five-dollar bill beside the government debt.

The truth that we should take to our hearts is the personal knowledge that we are engaged in a cold war for our survival as usefully free and independent agents in our society. It *is* war and nothing else, and it affords no leisure for temporizing, no possibility of compromise.

Now these may be strong words, but with all the good will in the world toward our fellow men, I do not see how we can afford anything but the plainest statement of the situation if we are to resolve our own thinking into a course of action. The time has come to set forth our beliefs in unmistakable terms and to do so, each of us, as thoughtful citizens carrying a responsibility to be articulate for the benefit of our respective communities.

From experience I think that I know something of the feelings which confront the hospital executive who thus is implored to *do* something. Perhaps in your own case you may be getting a little hardened to these repeated importunities. Even with the best intentions you are at a loss to know exactly what you can do. Moreover, you are busy. You may agree that action is essential, but someone else will have to undertake it. You have a hospital to run.

In these things you are certainly no different from your neighbors in a thousand other communities across the land—and therein lie the sprouted seeds of an emergency.

Most Americans are matter-of-fact about their liberties. They have had them for a long time, and it is hard to believe that they can be threatened by anything but a frontal attack. Most Americans are busy. The effort of earning a living consumes almost their whole energy, at least all of the energy that they feel they can spare for serious matters.

Most Americans are not sufficiently informed in regard to enterprises other than their own. They vote blindly, often knowing little or nothing about the true qualifications of their candidates; they leave politics almost strictly to the professionals; it takes a catastrophe in foreign affairs to shake them from their preoccupation with daily living; they expect government to be wasteful and inefficient and graft-ridden, and yet they entrust more and more of their own problems to government.

Perhaps, as individuals, we cannot always be sufficiently informed about either candidates or public issues to decide with judicial wisdom and impartiality. Perhaps we are too busy to acquire the information for deciding the relative merits of every involved issue that seems to demand our notice. We must delegate some responsibilities to others or there is chaos.

ONE ISSUE IS CLEAR

But we can and we must decide what is right in our own specialized field, and we must uphold that right with all our energy and determination. The threat that once was over the horizon is now on our doorstep; it is your own hearth and home that are at stake. And so far as hospital people are concerned, the issue is clear:

Are we to have voluntary hospitals, voluntary health care in America, or are we not?

You must answer that question for yourself. No one else can answer it for you. In your own community and within the sphere of your own hospital, you, your trustees, your administrative colleagues, your medical staff members alone have the knowledge and qualifications to reach a wise decision.

When you have reached that decision, for yourself as an individual or jointly with your associates, it is your duty as a citizen to see that your community understands how you have decided and why you decided that way. It is your duty to carry the flame of

your conviction into the meetings of your community or district hospital council, your state hospital association, the American Hospital Association. This is true whether you oppose or support compulsory national health insurance, for it is indifference and diffidence which destroy the democratic process, not forthright debate.

It is late, admittedly. For perfectly human reasons, the individual administrator must at times be preyed upon by a vitiating sense of despair in the face of the odds against which he, a single person, must fight.

Fifteen years ago those odds were more than reversed. There was no reason then to believe that the American people would ever authorize the federal government, by whatever means, to collect virtually all the money that the people have available for health services and then redistribute that money according to central notions as to how it should be spent.

THE NUMBER HAS GROWN

The influential advocates of this scheme in the mid-1930's could be counted on the fingers of one hand. Today an adding machine cannot calculate their number. Compulsory national health insurance has become a political issue. It has been sold outright to a formidable assemblage of powerful figures from the President on down.

If this seems discouraging, it is only because our memories are short. The tactics utilized by the proponents of nationalization, in the face of even greater odds, are an open book before us. Let us examine them briefly:

First, there was the creation of a "cause," of an excuse for drastic action. This has consisted of subtle dwelling upon the need for better medical and health services for Americans. Who can deny this need? Of course it exists. It always has existed and it always will exist no matter how brilliant our progress. And of course the health picture is filled with inequities caused by poor distribution, and with economic injustices, and with deficiencies in public understanding and education.

To those who will look, however, it is startlingly obvious that the worst injustices and inequities and inadequacies in the entire American system of health care are in those areas where government already has assumed responsibility.

There is in all the blighted zones of the South, in all the slums of northern cities, no spot blacker than that which obscures the health care of the Navaho Indians, who are the wards of the benevolent federal government.

There are no voluntary institutions, even those which would not be recognized as hospitals by any legitimate health group, which are worse sinkholes than the institutions for care of the mentally ill in many of our states, and these are state responsibilities.

Our war veterans are political footballs, shoved off in isolated institutions built at two to three times the cost of voluntary institutions, entirely divorced from the exchange of information and services which helps to keep standards of care at the highest level. Our indigents, whether the responsibilities of city or county governments, are herded into ramshackle, insanitary firetraps or forced into voluntary institutions at below-cost rates.

Before congratulating yourself at these evidences of the inferiority of governmental medicine, however, stop and think for a moment. *We* are the government—at least, we still are to a considerable extent. Whatever shortcomings government has are the magnifications of our own shortcomings as citizens. The plain truth is that we cannot trust our own sense of responsibility far enough to let government take it from our shoulders.

We in the voluntary health system have been charged with permitting the economy of American health care to be something less than perfect. We have partly hung our heads, partly defended ourselves. We have never yet launched a counterattack except in opposition to such will-o'-the-wisps as "regimentation" and "socialized medicine"—terms and concepts that are meaningless to the people we have tried to convince.

If we think that governmental medicine inevitably tends to be bad, a thousand proofs lie all about us. Have we flung them back at our critics in government? Have we sought to stir up the people with our message concerning health needs as have the proponents of compulsory national health insurance with theirs? Have we even had the courage to use plain terms, to state bluntly that out and out lies accompanied such propaganda devices as some of the official interpretations of Selective Service rejection figures?

As an individual in hospital work, you must decide whether or not to ask yourself a whole list of potentially discomforting questions. In your home town you are in a position to know more about the people's needs for hospital care than is anyone else.

To what extent have you accepted the responsibility for pointing out to your community the things that must be done to obtain better care: for the mentally ill in your state, for the indigent in your county, for the veterans in your community?

Have you tried to awaken the people to these needs, or have you somehow assumed that it was none of your business, or that ethical considerations demanded silence, or that forthright statements were indiscreet?

Have you protested vigorously against the housing of indigent patients in your institution at less than cost, a practice which means that you must assume part of government's function by "taxing" pay patients to make up the difference? Or, if you absorb this deficit as part of your charitable function, have you kept the people well informed about it?

Almost certainly there is a cause in your own community waiting for you to discover it, a need to which you must arouse your friends and neighbors lest they begin to believe that all progress, all worthy action originate on the Potomac.

The second element in the strategy of the advocates of nationalization has been the formulation of a program. This, of course, was compulsory national health insurance, with ramifications and side issues which already have increased the medical wards of the government to 24,000,000 in 1948, have multiplied the cost of federal health services by five since 1940.

WHAT HAVE HOSPITALS DONE?

In return, let us consider to what extent there has been effective program development by the hospitals associated in the voluntary system. It is my own feeling that the picture in this respect is bright at the national level, less rosy at the state and local levels.

The American Hospital Association itself was revitalized in 1943 when its income was quadrupled and its activities were greatly expanded. Few voluntary organizations can boast a greater achievement than the association's establishment of the Commission on Hospital Care, which then produced a monumental plan—a program—for the development and improvement of health care in America. This is only one direction in which the A.H.A. has burgeoned with good and constructive works.

On the national plane, however, there is still need for a pattern for the total progress of health care, both voluntary and governmental, for at least the next quarter century. The health functions of the federal government are scattered literally among forty-four departments and agencies and bureaus, with little or no coordination or even exchange of information.

Let it not be said that the voluntary hospital system is equally disorganized and confused. Someone must see American health care in its totality and bring simple order to the reflection that is mirrored in the public mind. It is to be feared that few persons today, even in the hospital field, really know what they want in many specific areas of our health system, and that even fewer have given serious and unprejudiced thought to the guiding principles by which we can evaluate new developments.

WHAT IS GOVERNMENT'S SPHERE?

What, truly, is the proper sphere of government—federal, state and local—in the democratic system of health care? If we can establish a principle in answer to this question, decisions affecting new proposals in the field are automatic in most instances, and even settlement of borderline cases is greatly eased.

What are the responsibilities of voluntary institutions? Thus far hospitals have not gone nearly so far as the medical profession has, for instance, in stating their standards and in seeking reasonable legislation to uphold them. Should hospitals insist that sound and sufficiently uniform licensure laws be installed in all states, or should the setting of standards be a governmental function? If the determination of standards is left to government, should this be a state function or a federal function? It would, of course, ultimately become the latter under compulsory national health insurance, for the federal government could not possibly pay out tax funds for hospital care to institutions which did not meet predetermined standards of care.

It is characteristic of the democratic process that out of the stress of crisis or need there sometimes emerges a great new resolution of principles which previously had remained nebulous and wordless even in the minds of leading thinkers. Such an impulse gave birth to the Declaration of Independence, to the Constitution, to the Emancipation Proclamation, to the Hippocratic Oath, to the Golden Rule which is the taproot of Christianity.

The impelling need for guidance through some such statement now confronts our hospitals. They cannot, in my opinion, look to government for objective determination of the principles by which they are to shape their own future, for government has no solution to any problem that does not expand its own powers. The hospitals can look only to themselves.

At the state level, the formulation of program is more difficult than at the national, since the mechanism for concerted action is not nearly so well developed. It is true that state hospital associations have gained stature and responsibility from passage of the Hospital Survey and Construction Act, and they serve highly valuable purposes in sponsoring discussion, cooperation and exchange of information.

I do not know of a single state association, however, which has a program other than that deriving from the Act or those resulting from immediate problems—nurse recruitment, for example. With a few notable exceptions, essentially the same comment can be made with regard to local and district hospital councils, where these exist at all.

The final major feature of the campaign promulgated by the apostles of nationalization has been public education. As previously indicated, I would be far more discreet to leave comment in this connection to someone else. We have little time remaining in which to get down to cases, however. There has been an immense outpouring of sheer propaganda by governmental agencies, notably the Bureau of Research and Statistics of the Federal Security Administration, while educational activity by the hospitals and voluntary health agencies is virtually nonexistent.

In whole states there is not a single voluntary hospital which has even a part-time worker in public education. So far as I know, not a single district hospital council or state association has an employe charged with the responsibility for public education. Typically, this duty is left to the secretary along with a thousand other seemingly more pressing responsibilities. Even the American Hospital Association, for all the good work it has accomplished in public education, has fewer than a half dozen employes in this department, including its director and all secretarial and stenographic help.

When you stack this pathetic situation up against the immense resources, the inexhaustible fund of tax dollars, the assured and respectful audience, the limitless staff of the Federal Security Administration, which is committed to the advocacy of compulsory national health insurance despite all theories that governmental agencies should remain impartial, it is no wonder that many of the people are being swayed from our present system of health care. They, the people, have heard only one side of the story.

I return to you, the individual hospital executive, as I make this statement. Aside from the issuance of various pieces of literature, the collaboration in occasional publicity, the staging of periodic observances such as National Hospital Day, do you have an educational program? Has it taught the people of your community what they can expect from your hospital, what they must contribute in support of it, where improvement is needed in both voluntary and governmental health care, how the improvement should be realized? Is your program organized, a part of the regular operation of your hospital?

YOU HAVE A HOSPITAL TO RUN

Yes, I know: You have a hospital to run. From repeated, first-hand observation I know how little time the typical administrator has to devote to public education. This problem is not like those associated with the care of patients. The patient has the prior claim on your attention; the education of the public always can wait until tomorrow. You haven't any money to spend on public education anyway. You have had all you can handle trying to keep up with inflation during the past few years. And finally, you can't get your trustees interested to the point of action. Public education is an intangible, and you have gotten along all right without it in the past.

I admit the truth and the power of all these arguments and of a dozen others in the same vein. Even if I could refute them, it is not my province to attempt to do so. My whole point is that the Pearl Harbor of voluntary health care in America has long been foreshadowed, and now the first bombshells are exploding. How are *you* going to respond?

The Bank Depends Upon Its Friends

Morristown's blood bank is a saga of cooperation among hospital, Red Cross, community and staff members

ROBERT G. BOYD
Director, Morristown Memorial Hospital, Morristown, N.J.

THE hospital isn't big enough for it." "We haven't any space for it." It would be too expensive to set up and operate." "We won't be able to keep it stocked." "Why not wait for the national Red Cross program? They'll probably soon start a blood bank in this area." "Where are we going to get another lab technician?"

These were some of the thoughts that kept plaguing us when we first seriously considered setting up a blood bank in this 122 bed general hospital. All of them are valid contraindications that might cause any hospital to hesitate about going ahead with such a project. Taken together, or even individually, they present such an adverse picture that I am afraid we would still not have a blood bank at Morristown Memorial if one certain thing hadn't happened. What started the chain reaction that finally yielded our blood bank was a $1000 donation from an anonymous donor — given us through the courtesy of one of our medical staff members.

The next move was to look for the necessary space. There wasn't a cubic inch available in our main building. For a while, it seemed there wasn't suitable space in any other building on our grounds. We finally found ourselves returning more and more rapidly to consideration of space in Havemeyer Pavilion, our contagion building. As a result of the decreased need for hospitalization of communicable diseases in recent years, it was obvious that space could readily be made available in that building. The only reason we hesitated to use the space for a blood bank was we were afraid that there would be a seriously adverse psychological reaction from the community at large because, for so many years, "Havemeyer" had spelled "Contagion" in the public mind.

The more we considered the matter the more convinced we became that the advantages would far outweigh the disadvantages and that it should be possible to avoid any untoward reactions by preparing the way with extreme care.

We were fortunate to get an immediately favorable response from Mr. and Mrs. P. H. B. Frelinghuysen who had donated Havemeyer Pavilion and from the Morris County Board of Chosen Freeholders which gives us a yearly appropriation to help offset the annual loss we sustain in operating our contagion service.

Meanwhile, of course, informal discussions with prominent members of our medical staff had shown quite clearly that the doctors would stand behind the project. We also obtained the informal concurrence of local Red Cross authorities and a group of voluntary blood donors called the "Community Blood Index."

With unanimous and enthusiastic support and understanding from these sources, we felt confident we could successfully present the project to the public with the able assistance of the local press. With encouragement from all sides, the project was formally recommended by our medical staff and immediately approved by our Committee of Managers which, in addition, supplemented the $1000 gift with a special appropriation of $5000.

The minute formal approval had been obtained all the way through we worked out our publicity with the local Index and the Red Cross. As a matter of fact, the publicity had been just about completely prepared beforehand, as it had seemed advisable to have the operational details worked out with both of the local organizations and our own staff before taking the matter to our Committee of Managers.

Our publicity emphasized that one end of Havemeyer had been closed off with a separate entrance and would be operated entirely apart from the contagion section of the building. There was one change in this part of our publicity program, however. While we had been discussing the blood bank, another "Havemeyer" project had developed even faster than the blood bank. This other project was a department of physical medicine. Consequently, the closing off of one end of Havemeyer for the care of communicable cases was interpreted to the public in connection with our physical medicine project, and repetition was not necessary when our blood bank was started in this same section of the building.

Once the initial impetus had been gained, the project progressed much

FIG. 1

FIG. 2

Fig. 1: Hospital volunteer registers first donor as Red Cross chairman and head of donors' Index look on. Fig. 2: The pathologist and his assistant supervise the blood donation.

faster than we had expected. A "bottleneck" in delivery of the necessary equipment did not develop. A one-year delay in delivery of the centrifuge was remedied through the loan of two small centrifuges by one of our suppliers. New equipment included a special refrigerator, centrifuge, work table, sink, water bath, and microscope at a total cost of $3600. Remodeling expense was less than $150.

A number of interesting problems arose. It became evident that "public relations" would continue to loom large in the picture—particularly in interpreting our blood bank problems and policies to the public. We were extremely fortunate with respect to one interesting coincidence: Winter Mead, chairman of the local Red Cross chapter, was one of our hospital trustees and, also, chairman of our public relations committee. One can readily imagine how extremely helpful he was in his tripartite capacities. He, Rev. Thomas W. Attridge, head of the Index, and Mrs. Elizabeth G. Farley, executive secretary of the local Red Cross chapter, were, and continue to be, of immeasurable assistance in the operations of the blood bank. Without their help, it would not have been possible to start the bank and keep it stocked with blood solely from volunteer sources.

One problem that arose immediately was that the publicity brought in volunteer donors at all hours. Naturally, these donors expected to have their blood taken immediately. Gradually but surely, through the help of the Red Cross and the Index, word was spread that the donors should not eat for at least three hours before giving their blood and should come to the bank only at certain announced times. The announced bleeding hours continue to be three mornings and two evenings each week. We found the evening hours to be especially productive in getting blood from the commuters returning home from New York between 5 and 7 p.m.

Another problem was the recruitment of donors. Here, too, the Red Cross and Index did a marvelous job. After appropriate advance publicity, mobile units were stationed on different occasions in the center of Morristown and in near-by municipalities, and numerous new Index recruits were obtained with the help of Red Cross volunteers and laboratory technicians (who typed the donors on the spot) from our two local hospitals.

We have had one change in our system for charging for the blood bank's services. It should be emphasized that throughout our planning and operations to date we have consistently stated that it is our basic policy to operate the bank without profit. At the same time, we have pointed out that in the face of a sizable annual operating deficit we could not afford to operate the bank at a loss. We have continually assured everyone concerned that our charges would be adjusted from time to time within these two limitations, and that we would be willing to use any reasonable charging system that might be recommended by the volunteer organizations cooperating with our bank.

In accordance with this policy, the local Red Cross chapter and the Index recommended the charging system that we used when the blood bank was started in May 1948, but we fixed the amount of the charges in accordance with our estimated expenses.

The Index assumed responsibility for keeping the bank stocked at all times. In return, the hospital agreed—in compliance with the wishes of the Index—to furnish blood to veterans and indigents in either of the two local hospitals without charge. With respect to other patients, it was agreed that the following schedule would prevail:

If friends or relatives of patient replaced two for one—no charge.

If they replaced one for one—$10 for each pint from the bank.

If there was no replacement—$20 for each pint from the bank.

Insofar as having ends meet financially was concerned, the foregoing charging system worked satisfactorily. It covered our operating expenses of about $500 a month for the issuance of from sixty to eighty pints of blood. However, the system was not suitable from the point of view of broadening the services of the bank to take care of the needs of other hospitals at distances ranging up to about 20 miles. We felt we should attempt to "broaden the base" not only to provide a needed service, but to improve our blood bank service through added volume. One thing we especially had in mind in this connection was to attain enough of a turnover and stock to justify separating liquid plasma and to avoid having to throw away whole blood from time to time because of expiration of the twenty-one day limit on its usability.

The cooperating volunteer organizations fully agreed on the desirability of expanding the blood bank's service area, and toward the end of 1948 merged into one organization called the "Red Cross Blood Donor Service." The local Red Cross chapter then offered to cooperate with Red Cross chapters in the vicinity of near-by hospitals to work out a plan whereby these hospitals might routinely receive blood from Morristown Memorial's blood bank.

At the same time we set up a different basis for charging (see "Rules Governing Blood Bank" in box on page 70). Under this new system, started Dec. 29, 1948:

1. There is no *required* replacement. The Red Cross Blood Donor Service is responsible for maintaining the supply of blood. However, we always do our best to persuade relatives and friends to give blood to the bank

FIG. 3 FIG. 4

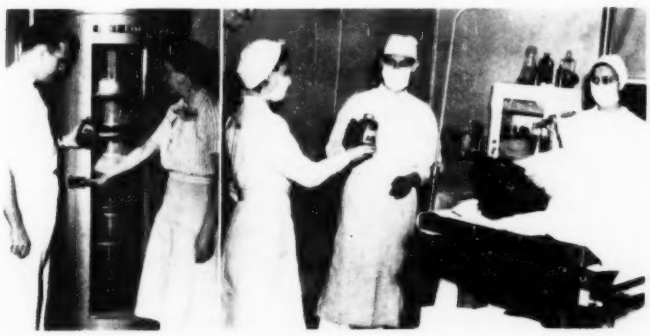

Fig. 3: The first pint of blood is stowed away safely in the refrigerator. Fig. 4: Blood from the bank is particularly valuable in meeting any emergencies that may arise on the maternity service.

to replace blood issued to a patient.

2. No credit is given for replacement blood.

3. A service charge of $12 is made for each pint of blood issued to a "pay" patient in the hospital. On the patient's bill we stamp a statement to the effect that no charge is made for the blood, which has been furnished by the Red Cross Blood Donor Service, and that the charge shown is a service charge for necessary blood bank and laboratory work.

4. A service charge of $10 is made each time blood is sent to another hospital. In each case of this kind we bill the hospital—not the patient. We make a smaller charge in such cases for two reasons. First of all, there are no bad debts. Second, there is less laboratory work involved on the average.

It is too early to determine definitely whether the foregoing charges will have to be adjusted. If an adjustment is necessary it will probably have to be upward. We have consistently tried to keep our charges "on the low side," and it is quite possible we may have been too optimistic in calculating the minimum figures that would cover the many things included in these service charges. Included within these charges are:

1. Reception, physical examination, and bleeding of the donors, as well as the processing (including all lab work) and storage of their blood.

2. Recipient's set.

3. All cross-matching. Another hospital may have this done (within the service charge) by sending us a sample of the recipient's blood.

A great deal has been said and written about the National Blood Program of the American Red Cross. Our experience has shown that the Red Cross program is sufficiently flexible to afford maximum cooperation to a hospital that decides to set up its own blood bank, provided there is a definite need and provided, further, that a true spirit of cooperation and helpfulness is felt and shown by the local Red Cross officials. The Red Cross officially recognizes the desirability of cooperating in such programs in the following statement in its pamphlet entitled "Your National Blood Program" issued in January 1948: "It is hoped that communities that have been planning or considering establishment of local blood programs with Red Cross assistance will proceed with their plans."

Last, but by no means least, I want to mention the leading rôle played by our entire laboratory staff in setting up the blood bank. All important is that first sentence in our "Rules Governing Blood Bank": "The Bank will be operated by the staff of the clinical and pathological laboratory at Morristown Memorial Hospital." Unless our laboratory staff had been willing to give much extra time and effort, I can state categorically that our blood bank would have been a dismal failure. Our pathologist, assistant pathologist, and chief technician have had to spend much extra time in meetings and other planning activities and in "ironing out" complaints. The entire laboratory staff has to give many added hours at very inconvenient times in receiving, examining and bleeding donors and in issuing blood in emergencies. On numerous occasions the technicians spend long hours on holidays and in evenings typing donors in cold, windy corners in recruitment drives in Morristown and near-by municipalities. Unless a hospital is privileged to have staff members of this caliber, I would strongly urge that it refrain from starting a program of this kind.

RULES GOVERNING BLOOD BANK

1. *Staff.* The bank will be operated by the staff of the clinical and pathological laboratory at Morristown Memorial Hospital.

2. *Who May Receive Blood From the Bank:*
   a. Any patient at Memorial Hospital.
   b. A patient at another hospital, provided such hospital assumes the responsibility for compensating the Bank in accordance with the procedure set forth below.

3. *Replacement Procedure.* Required replacement is no longer a part of our charging system. However, it is emphasized that the success of the Bank depends upon volunteer replacement by both the Red Cross Blood Donor Service *and relatives or friends of the patients to whom blood is furnished.* The Service cannot bear the entire burden of maintaining the necessary supply of blood in the Bank. Therefore, it is imperative that an appeal for replacement always be made to the relatives and friends of the patient receiving blood from the Bank.

4. *Nonprofit Policy.* As closely as practicable, Morristown Memorial Hospital will operate the Bank *without* profit. Charges may be adjusted from time to time in accord with this policy.

5. *Cooperation by Red Cross Blood Donor Service.* The Red Cross Blood Donor Service is responsible for replenishing the supply as necessary.

6. *Cooperating Hospitals.* A hospital is so classified when it has signified its desire to use the services of the Bank regularly. The Bank must depend on each cooperating hospital to furnish replacements through patients' relatives and friends, local members of a community blood Index, or in any other appropriate way that the cooperating hospital may desire.

7. *Charges.* As the Bank depends upon volunteer sources for its supply of blood and in view of the fact that the Bank operates under a nonprofit policy, no charge will be made for blood furnished from the Bank. However, a service charge is made to cover the Bank's operating expenses. Two types of service charge are made as follows:
   a. *Patient in Morristown Memorial Hospital.* The charge for a "pay" patient is $12 per pint. A ward or clinic patient is charged whatever he is able to pay not to exceed this amount.
   b. *Patient in a Cooperating Hospital.* The cooperating hospital is requested to pay a service charge of $10 per pint. When the blood is requested, the cooperating hospital may supply a sample of the patient's blood. The Bank will then do the necessary typing, cross-matching and determination of the Rh factor. A recipient's set is furnished as part of the service. All such laboratory work, together with the recipient's set, is included within the service charge.

8. *Policy Concerning Segregation.* The same policy will be followed as has been established for the National Blood Program of the Red Cross. The blood will be separately marked and made available as requested by the patient or his physician.

9. These rules take the place of Rules Governing Blood Bank issued on December 29, 1948.

Medical Staff:	*Committee of Managers:*
Frank H. Pinckney, M.D.	Robert G. Boyd
President	Director

Distribution: At MMH: Medical Staff Bulletin Board, Laboratory, Blood Bank, Admitting Officer, Business Office, Director of Nursing Service, Clinic Supervisor; Morristown, Madison-Chatham and Somerset Hills Chapters, ARC; following hospitals: All Souls', Aurora Institute, Community Hospital (Boonton), Dover General, Franklin, Greystone, Newton Memorial, Shonghum, Somerset, Victoria Foundation and Warren County.

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The WHY WHO HOW WHAT of the LICENSED ATTENDANT

OFTEN in hospital practice a problem presents itself from which the directors and superintendent would like to shy but which all officers must face, however difficult and perplexing it is. Each problem must be examined, studied and discussed. The solution is based on the particular needs of the hospital and the community.

One of the problems that is felt throughout the country at the present time, varying in intensity in different localities, is the shortage of nursing service. This shortage is felt not only in hospitals but in the homes and in the public health services. I can think of no other subject that results in so many varied reactions from groups of professional and lay persons as that of the licensed attendant which has arisen out of this nurse shortage.

By some this licensed attendant or vocational worker, known heretofore as the practical nurse, is considered an answer to prayer; by others she is viewed with suspicion and distrust.

SHE IS HERE TO STAY

Without question, this new vocational worker has come to stay. The questions now being asked about her are: What will she do? To what extent will she replace the graduate professional nurse? Who is she? What are her preparation and training? How is one to recognize her? What will she cost to hire? Where can she be used? Who will be responsible for her? Where and to what extent is she being used at present?

Let us consider first, *"why the licensed attendant?"* Although the present number of registered professional nurses is the largest in history, there is an acknowledged shortage of nursing service. Too often, in the hospitals the patients are forced to wait for even the simple attentions that mean so much to the comfort of mind as well as body: the window or the shade to be adjusted, the door to be opened or shut, a book just out of reach, a glass of water, a comforting word of reassurance. For these attentions the skilled nurse is called from the seriously ill patient, whereas an unskilled person, *i.e.* the licensed attendant, could give the same comfort to the patient. Many also are the instances in which the professional nurse is kept on by a convalescent patient long after her skill is needed.

The convalescent patient, as well as the subacute and the chronically ill, can well and safely be cared for by the licensed attendant. But the public must be informed about her; the hospital administrator must be willing to plan the use of these workers to the end that the distrust of them will be dissipated.

The cost of being sick is high, as is true of many other things in life. However we can turn away from the purchase of clothes, steaks, cars and even vacations, but when sickness overtakes us or a member of our family, the purchase of a hospital bed, the doctor's care and the nurse's service must be met, and we can only give ourselves thankfully over to our doctors and nurses and hospitals, praying both for recovery and for our money to last! Three professional nurses on a twenty-four-hour shift means lots of money! There can, however, be some relief from this heavy burden through the use of licensed attendants as soon as the physician feels that the skilled attention and care of the graduate nurse are no longer necessary. The salary for attendants has been set by some states to be not less than two-thirds of the minimum salary and not more than three-fourths of the salary of the staff hospital nurse and one-half the salary of the private duty professional nurse.

The licensed attendant, then, is needed to free the skilled professional nurse for the duties for which she has been trained, to afford better bedside care for the less seriously ill patients, and to lower, in some measure, the cost of nursing care to the public, both in hospitals and in homes.

Who is the licensed attendant? In the old sense of the word, the practical nurse was any capable woman experienced in the care of the sick in her own home and who liked caring for people. She could be hired to "do" for a family, which meant washing, ironing, cooking and following simple directions given by the doctor. She made herself generally useful and was a real prop to the spirits of the family. She was untrained in the present-day meaning of that term. She took what salary she could get. There are still many of these women who "nurse" for hire. Some are capable and realize their limitations. Others, however, have been known to call themselves "nurses" and ask and receive professional nurses' pay.

PRACTICAL NURSE DEFINED

In the new meaning of the term the practical nurse or licensed attendant is between the ages of 18 and 45, with a minimum education of eighth grade, and has been graduated from a prescribed course in practical nursing approved by the state board of nurse examiners of the state in which she resides. She cares for the sick, under supervision, in the homes and hospitals and assists in the public health field. She is licensed if she works in a state that has licensing laws. There appears to be no generally accepted uniform which she is to wear, but institutions have found it necessary to indicate her status in some way, through a certain color of uniform or sleeve chevron.

This new vocational worker has been taught certain technics and procedures in her course of instruction and this list is known to the doctors and the nursing staff in the hospital and to the doctor in charge of a home patient. The licensed attendant is an outgrowth of at least the last ten years' work and, more recently, of the war during which hospitals gladly accepted the help of trained volunteers as taught by the Red Cross. Not many of these volunteers have been shifted to a pay basis although at one time private duty nurses were fearful that volunteers would endanger their own employment status.

The next question is: What does the

Condensed from a paper presented at the New Mexico Hospital Association meeting, 1948.

licensed attendant do? Those duties defined by the Practical Nurse Association and approved by the National League of Nursing Education would seem best to consider. In condensed form they are as follows:

1. To provide suitable environment for the patient; care for flowers, make beds, care for equipment and personal belongings of the patient.

2. To carry out personal hygiene, bath, care of mouth, teeth and hair; feed patients.

3. To look after the physical and mental well being; help the patient to get out of bed, dress, walk.

4. To carry out or assist with diagnostic measures: weigh and measure the patient, observe and record signs and symptoms, collect specimens, assist with test meals and physical examinations.

5. To prepare supplies and surgical equipment.

6. To carry out therapeutic measures; enemas, colon irrigations, hot water bottles, ice caps, gargles; place the patient in various positions.

7. To help with special types of services: discharge, admission and care after death.

8. To apply and remove adhesive, bandages under direction.

WHAT OTHERS THINK OF HER

What do professional and lay groups think of this licensed attendant? To be frank, many in both groups think according to hearsay, prejudice and fear and not according to fact or knowledge. Some think in terms of competition and still others feel that the licensed attendant can take over the major part of bedside nursing. The board of directors of the American College of Surgeons recently advised hospitals to admit and to utilize the assistance of auxiliary workers and suggested that approved hospitals provide training for such vocational workers by means of short courses.

The A.H.A. has also advised the use of these vocational workers. The National Organization of Public Health Nursing says that to obtain the needed ratio of one public health nurse for each 10,000 population the professional nurse and the practical nurse must assist the public health nurse in those duties that do not require public health nursing per se. Universities have established courses leading to the certificate of practical nursing.

There are still, however, some directors of nursing who feel the employment of these licensed attendants and their recognition will be a detriment to the standards of professional nursing. Time will break down this feeling when the worth of these workers has shown their value. Some private duty nurses fear that they will have less work if the practical nurse is employed. There may be some basis for this fear since it appears that from time to time some hospital administrators employ women who are not properly trained and allow them the graduate uniform and the same salary as the professional nurse. This practice is also difficult for the patients because they become confused and uncertain about the type of nursing care they are paying for and receiving.

Where does the licensed attendant receive her training? This training and instruction may be had in any one of a number of schools all of which are approved by the National Association of Practical Nurses and the state board of nurse examiners of the state in which the schools are located. These courses are given by the Young Women's Christian Association, in community centers, public schools and universities. There appear to be three main types of schools other than the university school.

1. One type of school gives the theory and the student is placed in a selected hospital for practice. Such schools ask a tuition fee. An example of this type is the school conducted by the Household Nursing Association of Boston.

2. A second type is the vocational course for which no tuition is asked. The three months' theory is followed by practice in a hospital where the students are paid an allowance during the practice period. The School for Practical Nurses at Rochester, N.Y., and the Essex County Vocational High School are of this type.

3. A third type is conducted entirely within the hospital. Half of the approved schools are of this type of which the Central School for Practical Nurses of the New York City Department of Hospitals, the school at the Caledonia Hospital in Brooklyn, and the one at the Grace-New Haven Hospital, New Haven, Conn., are examples.

There are also courses for licensed attendants conducted jointly by public school systems and the nursing education associations, similar to the one in Nashville, Tenn. Classes have been started in Philadelphia with the cooperation of the public, the nursing profession, the hospitals and the public schools. The correspondence schools have fortunately decreased in number owing to the efforts of the American Nurses' Association. There are many objections to these schools and many young women have wasted their time through them and have been disillusioned when they apply for licensing upon the completion of the course.

What of the legislation governing the licensed attendant? Licensing is a recognized means for ensuring the protection of the American people in all fields: pharmacy, medicine, law and business. Why then should not the care of the sick by all types of persons who nurse for hire receive the same protection? And yet in this matter of life and death there are only twenty-six states, Hawaii and Puerto Rico which have such licensing laws, and only in Hawaii and New York State are the laws mandatory. It is the business of organized nursing to work with the practical nurse to obtain the passage of licensing laws. The support of the medical profession and of the public is needed for this protection of the people.

FIELDS OF EMPLOYMENT

The last question is "What is the present situation in the field of the licensed attendant?" As well as can be estimated there are now about 200,000 employed persons other than graduate registered nurses who nurse for hire. Of this number there are about 30,000 licensed practical nurses. It would seem, therefore, that the care of the American people when a graduate registered nurse is not employed is largely in the hands of unlicensed and unregulated persons. The newest field in which the licensed attendant is used is that of public health. The Visiting Nurse Association of New York City had a staff of eighteen practical nurses in 1945. Practical nurses are also employed in mental, tuberculosis, convalescent and Veterans Administration hospitals, as well as in industry and in doctors' offices.

In looking over the whole subject of the licensed attendant we see that the public must be informed of this aid in overcoming the shortage of nursing service. Individuals of a community cannot act until there are a plan and a leader. An active committee composed of members of the medical and nursing professions and hospital administrators working with lay organizations can accomplish much for the benefit of the community.

ACCOUNTING SHORT CUTS

Pay Roll Bank Reconciliation

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IT IS becoming increasingly common for hospitals to use pay roll checks instead of cash for paying salaries to employes. Since the number of pay roll checks issued during the month is generally large, particularly if checks are issued weekly, the reconciliation of the bank account each month consumes much time.

In the case of a Catholic hospital, if the pay roll checks are issued and controlled by a Sister, the bank reconciliation may be eliminated by, utilizing, at the least, two pay roll accounts in separate banks and issuing checks for alternate monthly periods on each account in accordance with the "Pay Roll Chart" commented upon later.

To avoid confusion between checks drawn on the two banks, the color of the checks on each bank should be different. The checks should also bear the imprint "Void after thirty days" in order to speed up deposit of the check by the payee and hence reduce the number of outstanding checks.

It is also advisable to request the bank not to charge the pay roll account for services. Instead, the charge should be made to the general checking account.

The pay roll chart illustrated herein is designed for a hospital that uses two banks, pays its employes semimonthly three days after each pay roll period and also issues checks to employes between pay roll periods on account of vacations, severance and so forth. It will be noted that the period for the pay roll checks to clear through the bank ranges from approximately six to ten weeks—ample time for most checks to clear through the bank.

For example, checks will be drawn on bank B for the two pay roll periods, last half of January and first half of February and will be dated January 16 to February 18. These checks, in all probability, will have cleared through the bank by March 31. If the pay roll bank balance is, say, $500—the amount originally deposited in the bank—and if at March 31 the balance is $500, then it may be assumed that all checks issued during the period from January 16 to February 18 have been presented for payment. It should be added that nothing need be done when the B bank statement and canceled checks are received for the month of February.

A further study of the pay roll chart will show, for example, that checks issued on bank B during the period March 16 to 31 may be presented to the bank prior to March 31 and thereby complicate matters. To avoid such complications it is necessary to use Method I or II, whichever applies.

METHOD I—ALL CASH RECEIPTS DEPOSITED INTACT:

1. Pay roll checks should be cashed by hospital from petty cash fund (assume that such checks which were issued during the period from January 16-31 totaled $100). Retain checks to the first of the following month to ensure their not clearing through the pay roll bank account during the month.

PAY ROLL CHART

SHOWING ON WHICH BANK CHECKS SHOULD BE DRAWN

Pay Roll Period	Bank on Which Checks Should Be Drawn	Date of Issuance of Checks for Separation Pay, Vacation, Etc.	Date of Issuance of Regular Pay Roll Checks	Bank Statements A	Bank Statements B
Jan. 1-15	A	Jan. 1-15	Jan. 18	Jan. 31, Feb. 28	
Jan. 16-31	B	Jan. 16-31*	Feb. 3		Feb. 28, Mar. 31
Feb. 1-15	B	Feb. 1-15	Feb. 18		
Feb. 16-28	A	Feb. 16-28*	Mar. 3	Mar. 31, Apr. 30	
Mar. 1-15	A	Mar. 1-15	Mar. 18		
Mar. 16-31	B	Mar. 16-31*	Apr. 3		Apr. 30, May 31
Apr. 1-15	B	Apr. 1-15	Apr. 18		
Apr. 16-30	A	Apr. 16-30*	May 3	May 31, June 30	
May 1-15	A	May 1-15	May 18		
May 16-31	B	May 16-31*	June 3		June 30, July 31
June 1-15	B	June 1-15	June 18		
June 16-30	A	June 16-30*	July 3	July 31, Aug. 31	
July 1-15	A	July 1-15	July 18		
July 16-31	B	July 16-31*	Aug. 3		Aug. 31, Sept. 30
Aug. 1-15	B	Aug. 1-15	Aug. 18		
Aug. 16-31	A	Aug. 16-31*	Sept. 3	Sept. 30, Oct. 31	
Sept. 1-15	A	Sept. 1-15	Sept. 18		
Sept. 16-30	B	Sept. 16-30*	Oct. 3		Oct. 31, Nov. 30
Oct. 1-15	B	Oct. 1-15	Oct. 18		
Oct. 16-31	A	Oct. 16-31*	Nov. 3	Nov. 30, Dec. 31	
Nov. 1-15	A	Nov. 1-15	Nov. 18		
Nov. 16-30	B	Nov. 16-30*	Dec. 3		Dec. 31, Jan. 31
Dec. 1-15	B	Dec. 1-15	Dec. 18		
Dec. 16-31	A	Dec. 16-31*	Jan. 3	Jan. 31, Feb. 28	

* See comment for cashing checks.

2. On the first of the following month the petty cashier should withdraw $100 from the deposit of patients' receipts and substitute therefor the cashed pay roll checks totaling $100.

METHOD II—CASH RECEIPTS NOT DEPOSITED INTACT:

1. Pay roll checks should be cashed by hospital from cash on hand (assume that such checks which were issued during the period from January 16-31 totaled $100). Retain checks to the first of the following month to ensure their not clearing through the pay roll bank account during the month.

2. On the first of the following month deposit checks in general checking account.

Obviously, if the aforementioned procedure is followed utilizing three bank accounts instead of two, then the possibility of outstanding checks at the end of ten weeks is still further decreased.

If it is not possible to establish two separate bank accounts, then we suggest the use of three or four different colored checks.

Hospitals that find it necessary to make monthly bank reconciliations will find the check sorting procedure devised by J. H. Myers, associate professor of business statistics, Northwestern University, to be quite a time saver. He suggests the following steps* for sorting checks:

Step 1: Sort the checks into ten piles according to the last digit of the check number. All checks ending in 0 go in the first pile, those ending with 1 in the second pile, and so on. The checks are to be placed *face down* in the pile. (This is not necessary in the first step, but since it will be necessary in other steps a consistent practice might as well be used from the first.)

Step 2: Pick up piles starting with the "0" pile and place each pile on top of those in hand. All the time maintain the *face down* position of the checks.

Step 3: Turn the pile right side up and sort the checks into piles according to the second last digit and place the checks *face down* in the piles.

Step 4: Pick up piles starting with the "0" *pile* placing each on top of those in hand, again maintaining the *face down* position of the checks.

Step 5: Repeat step 3 but sort according to the third last digit.

Step 6: Repeat step 4, and so on by the identical procedure until the sorting is complete.

This procedure is identical to that used in sorting operations with mechanical equipment.

*Excerpt from the Journal of Accountancy, December 1947.

Formula for Better Collections:

GET IT WHILE THEY'VE GOT IT

DANIEL G. GILL
Credit Manager
Pennsylvania Hospital
Philadelphia

LIKE most people starting on a new assignment, I had grave doubts about entering the field of hospital credit management. Reference during the preemployment interview to deficit budgeting, large outstanding accounts, charity cases, and the mounting cost of hospital care had created an impression that the possibilities of achievement might be limited. Further, it seemed doubtful that the application of sound business-like credit policies would prove effective in view of these conditions, the over-all high cost of living, and the traditionally liberal attitude of hospitals toward patients.

Fortunately, this feeling of uncertainty was of short duration. After a few months of observation it became convincingly evident that greater support for the hospital could be derived from patients; that a large percentage of the existing accounts receivable could be recovered by proper follow-up, and, most important, that various procedures could be introduced to guarantee payment in full or in part by most patients at the time of admission, thus reducing outstanding accounts and minimizing losses from bad debts.

It is the desire of all hospitals to collect their accounts in full either in advance or upon discharge. Many have attempted to achieve this goal by requiring all patients to pay one week's room and board plus an amount estimated to cover auxiliary charges at the time of admission. Experience has shown, however, that few patients are prepared to pay at this time. Furthermore, since the first interview is invariably conducted when the patient reports for admission, it is practically impossible to enforce the policy. Failure to impress patients with the necessity of paying for hospital care before they are admitted usually leads to nonpayment during hospitalization or at discharge and is the major underlying cause of the inflated accounts receivable and bad debts which all hospitals have experienced.

There is no denying the need for public education and advance payment, but a payment in advance policy can never have meaning unless admitting officers have authority to force compliance. Such a policy can be enforced by the adoption of procedures which cause all elective cases to be registered and interviewed in advance of the actual date of admission so that the necessary arrangements for advance payment can be made. This preadmission registration plan is based on a system of classifying patients as to urgency of admission, and at the Pennsylvania Hospital, Philadelphia, it has been designed to cover all patients admitted to the wards.

Patients are assigned to one of three admission-priority groups. P-I indicates an emergency case whose admission cannot be postponed beyond the original date. P-II designates a patient who, whether he is a surgical case or not, must have bed care but whose admission can be delayed for as long as three weeks. The last, P-III, signifies a patient for whom bed care is desirable but whose admission may be postponed indefinitely. Each patient's classification is obtained from the examining physician, with the attending nurse or

clerk responsible for requesting and recording the information on special forms.

In order to achieve the full benefit of preadmission registration, it is necessary to set up procedures to cover patients referred from all sources, with the system of urgency ratings applying to all. For example, outpatient department referrals are processed in the following manner: After the examining physician has decided that an individual must be hospitalized for treatment, he so informs the attending clerk, giving the diagnosis, urgency classification, and any additional information necessary for the reception and care of the patient.

The clerk records these data (diagnosis excluded) on a standard admission form, which is then given to the patient for identification upon admission. The clerk also prepares a medical history face sheet showing the individual's classification, name, address and other pertinent facts, plus an itemized record of all recent tests or treatments. This face sheet becomes the first page of the individual's case history with the list of services shown in order to prevent needless duplication of expensive tests or treatments. Upon completion of the forms, the patient is escorted to the credit department to discuss financial arrangements.

Upon reaching the credit department, the patient is immediately interviewed. All essential information—including employment, income from all sources, rent, dependents, debts and hospitalization insurance—is recorded on a standard credit form. To determine the estimated cost of hospitalization, careful consideration is given to the type of illness and treatment and the probable length of stay. Then, to determine the rate of charge (percentage of full daily rate), income and expenses are considered.

Each patient, whether he is rated full pay or part pay, is told that upon admission he must pay the estimated bill in full. If there is a reason why this cannot be done, arrangements are made to accept partial payment in advance. However, in every case a suitable plan is agreed upon before admission for the ultimate liquidation, often on an installment basis, of the balance due. It is upon our ability to educate the patient to his financial responsibility before admission that the success of the entire plan rests.

Admission dates are determined by patients' priority rating. When the patient reports for admission he is referred to the credit department to make payment. Anyone who fails to bring the specified amount is reinterviewed to determine the reasons for his failure, and each case is settled on the basis of its classification. P-I cases are admitted irrespective of preparedness to pay. The admission of those classified as P-III usually is postponed until the patient is able to make the required payment, while in P-II cases the examining doctor or chief resident physician is consulted to determine whether the patient's admission can possibly be delayed.

At this hospital all ward patients—including accident cases, referrals by staff doctors or other practitioners, and those who simply apply for treatment—are officially admitted to the hospital through the emergency department. Preadmission registration of these cases is effected through the same procedure as that described above. Each individual is classified as to urgency of admission by a resident physician. Emergency cases are, of course, admitted without delay, and the financial interview is postponed until the patient's condition has improved or contact has been made with a responsible person. Elective cases are referred either to the outpatient department for preliminary treatment and ultimate preadmission registration or directly to the credit department for interview and establishment of an admission date based upon the patient's classification and ability to raise the necessary advance payment.

The advantages of preadmission registration are numerous. It not only is a means of enforcing advance payment but also affords an opportunity to investigate doubtful information, insurance coverage, and many other important factors. Further, preadmission interviews can be conducted leisurely inasmuch as there is no necessity for rushing patients through as would be the case with unregistered patients for whom treatment arrangements alone had been set up in advance.

The hospital is not the sole benefactor of preregistration; there are numerous advantages for patients. Foremost is the fact that interviews are conducted at a time when patients are not faced with the anxiety and fear of immediate hospitalization. This leads to a more rational discussion of charges and a better understanding between individuals and the hospital. Second, by having advance knowledge of approximate costs, patients can make the necessary budget arrangements and enter the hospital with a minimum of worry about the necessity for meeting bills larger than can be paid. Finally, time required for actual admission is shortened because necessary forms have been completed in advance.

In this critical era of high costs and expensive service, the voluntary hospital must utilize extreme caution in granting charity to patients. Each individual must pay to the best of his ability if the hospital is to survive. We feel that the adoption of a plan similar to the Pennsylvania Hospital preadmission registration plan, while working no hardship whatsoever on patients because it is based on ability to pay, may be of great value in bringing about increased patient income and proportionately reduced losses.

WHERE WOULD OUR HOSPITALS BE?

If we should get some form of socialized medicine, what would happen to our hospitals? How are hospitals getting along under Great Britain's nationalized health service? What do hospital administrators there think about the program? To get the answers to these and other questions of vital importance to every American hospital today, one of the editors of The MODERN HOSPITAL has been in England for several weeks gathering material for a series of articles that will reveal the facts of hospital life under a national health service. The first article in the series will appear next month.

Acme Photographs.

IT CAN HAPPEN HERE

75 DIE IN EFFINGHAM FIRE

SEVENTY-FIVE patients and staff members died in the worst hospital fire since the Cleveland Clinic disaster (May 1929) when flames roared through St. Anthony's Hospital, Effingham, Ill., shortly before midnight April 4.

The fire apparently started in the basement and mushroomed up through elevator shafts and the laundry chute. When smoke was discovered issuing from the laundry chute, Sister Anastasia, in charge of the building, notified the building engineer, city firemen and the convent next door.

Fire companies within a radius of 35 miles responded to the alarm, but the flames gained headway with such speed that the building was destroyed within an hour. Most of the 45 patients who survived were in rooms on the first floor; some of those on the second floor were believed to have escaped by sliding down an enclosed chute, while patients on the third floor were trapped in their rooms and either jumped from windows or died in the flames.

Among the dead were 12 new-born infants; Nurse Fern Riley in charge of the maternity ward; Mrs. Shirley Clements, another lay nurse; two nuns, Sister Bertin and Sister Eustachia, and the hospital chaplain, Rev. Charles C. Sandon.

The three-story brick hospital, built in 1876, was considered fireproof. Records of the state fire department indicated that all safety recommendations of the fire marshal's office, including the cutting of exits and installation of slide fire escapes, had been complied with. The latest inspection, made six weeks prior to the fire, revealed nothing that would have caused the conflagration, according to Sister Cecilianne, Mother Superior of the hospital.

Although the source of the fire could not be determined, and will probably never be known, state fire officials declared that there were a number of causes for the rapid spread of the flames and gases. These included two open stairways that funneled the fire up through the corridors, and the use of nonfire-resistant materials on floors, walls and ceilings, which fed the flames. In the opinion of Patrick Kelly, state fire marshal, most of those who perished were dead "before the fire got a good hold on the hospital." They suffocated from smoke and fumes liberated by the heated wall paints, wall and floor coverings and burning wood, he believes.

Another element in the heavy loss of life was the fact that the labyrinth of connecting corridors made it difficult for anyone not familiar with the hospital to find his way to the exits which were located at the ends of the corridors.

The disaster was the first major fire in a hospital operated by the Hospital Sisters of the Third Order of St. Francis.

Plans for rebuilding the institution got underway immediately. Fifteen leading citizens organized the Effingham Civic Fund to finance a new 150 bed hospital to cost an estimated $2,500,000. According to the co-chairmen of the fund, J. William Everhart and George Dehn, the state and the federal governments will contribute $800,000 each and insurance on the destroyed hospital will amount to $200,000 more. The Sisters of the Order estimated that they could raise $300,000 for the new building. This would leave $300,000 to be provided by popular subscription.

In the meantime, a Quonset hut field hospital is being planned to serve the community until the new building can be erected. The hospital will be established by the army with the navy cooperating. All supplies and equip-

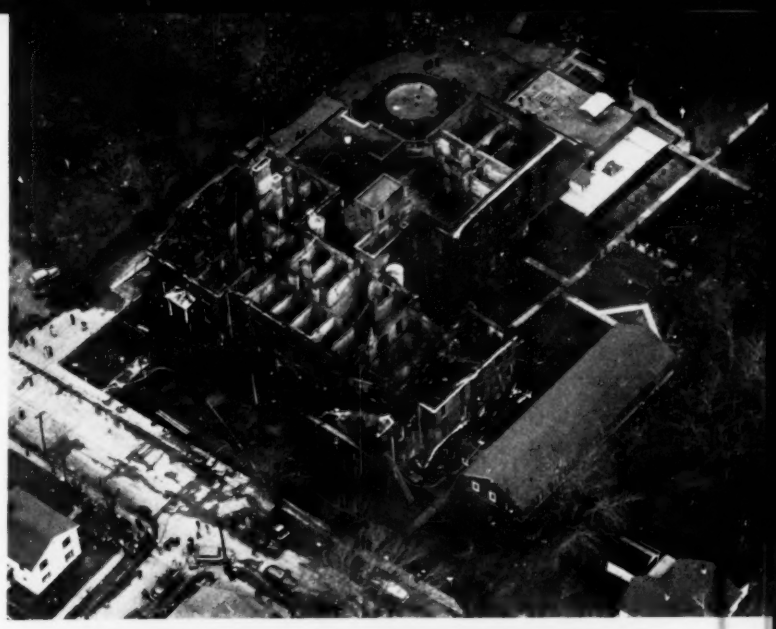
ment needed will be provided by the services.

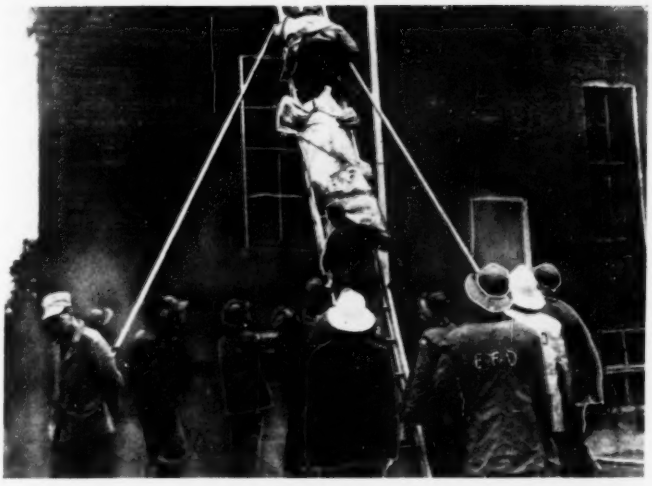
Hospital leaders and public officials agreed that the disaster pointed up the need for improved construction and fire safety devices in hospitals. Gov. Adlai Stevenson, who flew to Effingham to inspect the scene, stated that "undoubtedly, we can derive some vital lessons for hospital construction and fire discipline."

In a statement to The MODERN HOSPITAL, George Bugbee, executive director of the A. H. A., stated: "Careful investigation of the Effingham Hospital fire shows that the Sisters who administered this hospital had done everything requested of them by state and local fire inspection authorities to prevent the tragedy which occurred. Nevertheless, a number of fire safety measures, such as sprinkler systems, fire walls, and fire detection equipment, might well have prevented this tragedy had their installation been recommended to the Sisters. Hospitals everywhere will be alert to the need for greater emphasis on safety and fire prevention programs. There appears to be need for a uniform standard outlining structural requirements for fireproof and nonfireproof hospital buildings for the guidance of hospital administration and licensing authorities."

Memorial services for the fire victims were held April 12 in the picnic grounds next to the wreckage of the hospital, in which three victims were still buried. At the services speakers broadcast an appeal for funds to rebuild the hospital as a safe fire-resistant structure. Contributions of nearly $47,000 had already been received, among them a check for $5000 from Fred Snite Jr., the Chicago poliomyelitis sufferer who lives in an iron lung.

It was announced that Effingham and Shelby counties, now without a maternity hospital, have established a home childbirth and nursing service. Under the plan, a preliminary nursing visit will be made to each expectant mother. Free nursing attendance will be provided in the homes at birth and after delivery.





The four pictures on these pages tell their own story. The reaction of the whole country to the disaster is epitomized by the expression on the faces of the soldier and of the nun trying to identify the body.

About People

Administrators

Dr. Dean A. Clark, director of medical services of the Health Insurance Plan of Greater New York, has been named director of Massachusetts General Hospital, Boston. Dr. Clark will succeed **Dr. Nathaniel W. Faxon,** who is retiring after twenty years as director of the hospital.

Dr. Clark, an expert on public health and group medical service, was graduated from Johns Hopkins Medical School and subsequently served at Johns Hopkins Hospital, New York Hospital, Cornell Medical College and Trudeau Sanatorium. He is associate professor of public health practice at Columbia University and a lecturer in medical economics at the University of California.

N. W. Faxon

Dean A. Clark

Dr. Faxon was appointed assistant director of Massachusetts General in 1919, a position he held until 1922 when he became director of Strong Memorial Hospital, Rochester, N.Y. In 1935, he left Rochester to return to Massachusetts General Hospital as director. Dr. Faxon served as president of the American Hospital Association in 1933-34; he is a fellow of the American College of Hospital Administrators.

Dr. Alfred M. Stanley, senior director of Harlem Valley State Hospital, Wingdale, N.Y., since 1944, has been appointed senior director of Rockland State Hospital, Orangeburg. **Dr. O. A. Kilpatrick,** who had been acting director at Rockland, is now director of Rochester State Hospital. **Dr. Leo P. O'Donnell,** director of Newark State School, succeeds Dr. Stanley as senior director of Harlem Valley.

Leo G. Schmelzer, whose resignation as superintendent of George Washington University Hospital, Washington, D.C., was reported in these columns last month, is now administrator of Garfield Memorial Hospital, Washington. Mr. Schmelzer was reported to have accepted a position with the U.S. Public Health Service. His decision to head the Garfield staff was made after The MODERN HOSPITAL went to press.

Victor F. Ludwig, formerly assistant to the president and general manager, Kahler Corporation, Rochester, Minn., succeeds Mr. Schmelzer at George Washington.

Dr. William B. Talbot, whose resignation from New York Post-Graduate Medical School and Hospital, New York City, was reported last month, has been named assistant to the president of the Institute of Living, Hartford, Conn.

Dr. Francis J. O'Neill has been appointed director of Utica State Hospital, the oldest mental institution in New York's system, established more than 100 years ago. He had been assistant director of Central Islip State Hospital since 1946, having entered state service at that hospital in 1933.

W. Crane Lyon has returned to the hospital administration field, having assumed his duties as general manager of the House of St. Giles the Cripple, Inc., Brooklyn, N.Y.

Eva H. Erickson, administrator of Olean General Hospital, Olean, N.Y., has resigned that position to return to her former post as administrator of Galesburg Cottage Hospital, Galesburg, Ill. She will succeed **Leon A. Bondi.**

Col. N. J. Sepp, assistant administrator of Western Pennsylvania Hospital, Pittsburgh, will retire in June to take up residence in Florida.

L. F. C. Kirby, assistant director of Vancouver General Hospital, Vancouver, B.C., assumes his duties this month as director of the Royal Columbian Hospital, New Westminster, B.C. Mr. Kirby had been associated with the Vancouver General Hospital for 22 years.

Albertina Six, former administrator of Lewiston Hospital, Lewiston, Pa., is now administrator of Retreat for the Sick, Richmond, Va.

Dr. Joe R. Clemmons, medical director and executive vice president of Roosevelt Hospital, New York City, until his retirement January 1, died April 2. He was 52 years old. Prior to becoming associated with Roosevelt Hospital in 1937, Dr. Clemmons was assistant director of Strong Memorial Hospital, Rochester, N.Y. Dr. Clemmons was a fellow of the American College of Hospital Administrators and of the American Medical Association, and a member of the American Hospital Association, the Greater New York Hospital Association, and the American Public Health Association.

During the war he served as state chairman for physicians in the procurement and assignment service of the War Manpower Commission and received a citation from President Truman for his work in this capacity.

Robert E. Henwood has assumed the newly created post of administrative assistant at Cedars of Lebanon Hospital, Los Angeles. Mr. Henwood received his degree in hospital administration from Northwestern University. He just recently completed a residency in hospital administration at Los Angeles County General Hospital.

Eleanor M. Brown, former business manager of the American Stomach Hospital, Philadelphia, has succeeded **Beatrice D. Hervey** as superintendent of Centre County Hospital, Bellefonte, Pa.

M. Gladys Larrabee, superintendent of Claremont General Hospital, Claremont, N.H., for the last 25 years, has resigned to become superintendent of Beatrice Weeks Memorial Hospital, Lancaster, N.H.

Clara Coleman, R.N., has resigned as administrator of Trumbull Memorial Hospital, Warren, Ohio. She had been head of the hospital for eight and a half years. Miss Coleman's successor is **John F. Latcham,** assistant director of Rhode Island Hospital, Providence, R.I.

(*Continued on Page* 162.)

FILE UNDER CASE HISTORY

Your patient's I. V. record is a part of our case history

Keeping medical histories is part of our job, too. —Every Cutter Saftiflask Solution has to pass a test-by-test report before the complete case history is filed in our permanent records: *physical checks* of containers and closures... qualitative and quantitative *chemical tests* of ingredients... *solution assays* before filling... *chemical analysis* of the filled Saftiflasks, to confirm accuracy and purity of formula... *sterilization*, under rigidly maintained recorded temperatures... *visual inspection* of every sealed Saftiflask. Then, selected Saftiflasks, from each sterilizer load, go "On Test"...

Chemical Tests ... assay, after sterilization, verifies purity, formula, and concentration of solution.

Pyrogen Tests...on control rabbits, by intravenous injection; a temperature rise of as little as six-tenths of one degree rejects the solution.

Sterility Tests ... on inoculated media incubated for seven days, to check against aerobic and anaerobic contamination.

Physical Tests ... by high vacuum gauge to assure Saftiflask vacuum standards.

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SPEAKING OF AUXILIARIES

(*Continued From Page* 48.)

On the other hand, the job of public relations, of convincing people that a hospital in the community is essential, is one way of getting them to realize that they must support it through the community chest. We have worked on that tack and have tried to enlarge on it.

MR. SLOAN: One of the astounding examples of what women have done and can do in raising money was evidenced in New York last spring by the party given by the Women's Society of Memorial Hospital.

MRS. DELAFIELD: We always have a "Salute to Summer" party, because it seems that a cancer hospital should have one real fun party. Last year we had quite a number of highly desirable prizes. Then we persuaded the Savoy-Plaza to give us rooms on the second floor. We counted on having 500 people, and we got help from various theatrical people, which assured us additional publicity.

Well, 850 people came, out of a list of 3000. We decided we would charge a flat rate which included refreshments, and nobody would be obliged to put his hand into his pocket from there on in. The result was that we cleared $40,000 on the party.

THEY WANT TO GIVE

We are not having prizes this year because everybody agreed it was a terrible headache. But we are going to have a plain fun party. I think it is a marvelous idea; it makes wonderful public relations. We always make special rates for the personnel, of course, and everybody in the hospital comes. It is amazing what a fund raiser it is. People produce big checks who never have given before, no matter what they heard about the needs. The party just makes everyone feel he wants to give.

MRS. DIXON: That is wonderful. I think that you can see the value of a national organization in which the different types of organizations can compare notes and decide whether or not their own auxiliaries are doing the best they can. They get ideas from one another and pool everything. The national group is not to accumulate money but to accumulate ideas.

MRS. DELAFIELD: But I would like to ask, "Are you reconciled, in the vital need for raising funds for your hospital, with other groups that are trying to fill the same need?" I do not believe the problem has been solved.

MRS. DIXON: I attended an annual meeting in a city that has a community chest. The auxiliary had invited the head of the community chest to come to its annual meeting. She was much impressed with what the volunteers were doing. I think it eliminated all of her feeling that they were trying to take something away from the community chest.

CASE FOR CENTRAL EFFORT

MRS. DELAFIELD: You can see, Mrs. Dixon, the argument on the part of a central organization in a big city that every woman who raises funds for a hospital should be devoting that effort to the central organization.

MISS JOHNSON: Of course, in theory it is better that the fund raising be done by one central organization, is it not?

MRS. DELAFIELD: In theory, it is better.

MISS JOHNSON: Then when you are giving, you are giving once, and it it much better for the person who is giving, as it is for the community chest.

MRS. DELAFIELD: In theory, it is definitely good.

MISS JOHNSON: Of course, we are having difficulty in getting sufficient money. We serve an area where there are four community chests, but we are not getting sufficient funds from our community chests. However, none of us feels that we would be better off without the community chest.

I am interested to know what some of the hospitals here are doing as far as men volunteers are concerned. How do you develop the men for members of the board of trustees? Do you just pick them out of the community, or are they people who are selected for certain abilities? Do they know anything about the hospital before they are selected?

MR. SLOAN: We are making progress. Originally, board members were selected because they were the friends of some other board member or because they were socially prominent or were financially able to help. Today the trend is to make the board truly representative of the particular community, a cross-section of its citizenry.

MISS JOHNSON: It has always been the feeling that all board committees must be made up of members of the board of trustees, sort of within the circle.

I am also director of public relations. In the last two or three years we have enlarged our public relations committee and have taken on men from the community who are not members of the board of trustees. It has been an interesting development; these men on the committee are just as much interested as any trustee.

We also find our trustees looking toward these men as being representative people and being well informed about the hospital. They are going to make good future board members.

I am wondering if we should not be doing more of that in our committee work in boards of trustees, so that we are developing or finding good material for board members in the future.

MR. SLOAN: Definitely. Hospitals are going out and selecting as board members people who can contribute something from their backgrounds or their work.

MRS. DELAFIELD: Do you mean that men take part in the volunteer work in the hospitals?

SHOULD BE ENCOURAGED

MISS JOHNSON: The only way we are using men now, outside of the board of trustees, is on our public relations committee. My question is, isn't that a development that should be encouraged in other committees? There are not too many jobs within a hospital that men can work at as volunteers, but we have 10 members on our public relations committee, six of whom are men who are not members or who have no other connection with the hospital.

We had great fear in taking on these men. I know it was a question as to how they were going to work out.

DR. BROWN: I am not sure that Mountainside's public relations group would fit in well with the changing

concept of limiting the term of office of trustees. In the effort to get a changing group of people, you do not want to throw them all out at once. You want a progressive representation of more of the community. It means that people, while they are on the board, can afford to show a really concerted interest in the hospital.

Some boards, which have been self-perpetuating for many years, have grown larger in an effort to bring in people who have definite interest. At the same time, those who had been there many years are still interested, but their activities and other interests in life carry them away, and the institution is not their central interest. It is certainly an acute problem.

MR. SLOAN: Perhaps we should touch upon the attitude of the administrator and the women's group toward certain individuals who may become a bit overzealous in their desire to be of help.

MRS. BROWNELL: Pressure groups?

MR. SLOAN: Yes, the pressure groups. We know that in such matters as interior decoration women can be—shall I say?—a little difficult.

DR. BROWN: If the channels of operation are pretty well organized, and particularly if you have a paid director, you have some safety. You gain your liaison through that person, and she can guard you and guide you with the rest of the group, and they, in turn, with you.

FAILS TO CONSIDER COSTS

What has chilled a great many administrators has been the overzealous person who, with good intent, thinks of—let us pick up Mr. Sloan's point—interior decoration in the same way she does for her home. She brings in an interior decorator and quite loses sight of the fact she is in a hospital. May I wrongly or rightly put dollars first? She fails to consider costs, for instance. The next thing is the quality and fitness of decoration. Hospital finishes are different from those in a home. You cannot bring in things that are merely eye-appealing; they may not be suitable.

I should like to add this: That when the auxiliary supports something, and then later it becomes definite enough so that it contributes to and is recognized as part of patient care, the hospital should take it over.

There are times when you women are so ambitious and full of endeavor that you outstrip our budget! At Johns Hopkins they have an excellent mode of operation. The monies which the auxiliaries earn this year are held and not spent but are translated into a prearranged budget for the following year. In other words, the forecast is on

birds in the hand. One of the major projects was interest in social service; they underwrote close to half the budget—and continued to do it.

We were desperate for certain other types of assistance and quietly campaigned for it. I tried to sell the idea that there might be more tangible things that would be just as acceptable because in the end we all work for one thing in an institution. We have to be careful that we do not crowd the employed person off the map, but if our end results benefit the hospital and contribute to the care of the patient, that should be our aim.

How your funds are translated, how your service is translated should be back of your thinking. If dollars are short, our minds get more expansive, and we need you more.

MRS. DIXON: Dr. Brown, through the national program and also through the state programs we are hoping to have these more ambitious women associate with the auxiliary members who are there only to the point of helping the hospital, instead of trying to dictate. By having them associate with these other women, they will see the light. They will see for themselves where they have become over-ambitious.

DR. BROWN: Believe me, Mrs. Dixon, I think it is not half as much the women's fault as it is the administrators.'

MISS JOHNSON: I should like to say something for the administration. For the busy administrator there is nothing worse than being heckled by a group of women wanting to do something they think is worthwhile. Maybe they want to do over a floor of the hospital and do it over the way they want it done. I have great sympathy for that administrator, and I think when there is a women's auxiliary, and a large group of volunteers, they need to be guided by an assistant to the administrator, so that they do not get the habit of taking those details to the administrator himself.

There is a lot of listening that somebody has to do. No busy administrator could ever stand around and do it. I think that is where volunteers in hospitals fail many times, because there is no liaison between them and the administrator.

MRS. DIXON: That is what I meant, that they would get along better if they would find and associate with an auxiliary which was not too ambitious and which was not heckling the administrator.

MISS JOHNSON: You were speaking of the decorating. We have had some of those problems, too. Our auxiliary has a house committee, which does many wonderful things in the hospital.

We have learned that by combining representatives from our committees and the administration we can work out a plan nicely, and everybody is happy, including the hospital personnel. There was an example of that recently, in doing over the main cafeteria. The women's auxiliary had very definite ideas. The administration and the paid personnel had an idea of what they would like to have down there, and the house and grounds committee also had ideas. The people who really knew what it was going to cost and what we had to pay for it had some ideas, too.

EVERYBODY WAS HAPPY

Well, it was accomplished by getting together, sitting down, and saying, "This would be nice, and this other thing would be nice, but these are the actual facts. We have to choose, so we will pool our ideas."

As a result, everybody was happy.

MRS. DELAFIELD: We do that, too, with our house committee, only we did decide, in our original policy, that any time we wanted to do anything we would raise the funds for it first before we went ahead.

Our house committee has redecorated the hospital on exactly the basis that you have described. It got together with certain people in the administrative staff, subject to the rules of the hospital. We were able to bring in quite a few more frills, because the women raised the funds for them.

MR. SLOAN: But supposing that there were things in the hospital, from the standpoint of administration, that meant much more than some of those frills; what would happen then?

MRS. DELAFIELD: I will tell you exactly what happens.

We have a list of priority needs as well as a list in what we call our "projects book." We try to sell these priorities to each individual or group that we approach. That is part of our educational program. We interest a group. We try to interest it in contributing something vital to the hospital. Those priorities are worked out with the hospital administrator. However, if you get a group of women, such as we have, who are pre-

dominantly interested in decorating, we have to spend that money for decorating.

MR. SLOAN: Even though the hospital needs something else much more?

MRS. DELAFIELD: Even though the hospital needs something more.

MISS JOHNSON: The administration of the hospital has something to say about what the decorating will be?

MRS. DELAFIELD: The administration of the hospital has a great deal to say.

MRS. BROWNELL: Doesn't that point up, really, a danger that you can run into in a volunteer group? You can get them interested in one thing, and they become a pressure group. It can be nursing, and they will go whole hog to push nursing. Then the nursing department feels that it has the ear of the volunteers!

The greatest care must be taken, in my mind, not to give the impression to any department in the hospital that you would do anything without the administrator.

MR. SLOAN: We must recognize that, naturally. It can be done through the educational process of those auxiliary members, volunteers and trustees; the more you educate them the greater interest you develop on their part. Also the greater the problems you may be developing. But those are problems that the administrator must face.

MRS. BROWNELL: They can be alleviated greatly if the volunteer and auxiliary groups are conscious of the fact that the knowledge must be overall and the work must be over-all.

It must not be channeled into one phase—interior decorating, for instance. That is the headache of every hospital. More gray hairs are caused on the administrator's head by the woman who wants pink satin than by anything else.

MISS JOHNSON: Shouldn't every administrator have a chart showing where the auxiliary fits in?

MR. SLOAN: Every administrator should have an organization chart, clearly showing all lines of authority.

MISS JOHNSON: We try to get all our different groups together. We are always drawing little charts on the blackboard to show where each person belongs and what her relationship is to the person who is in charge of her department, and her relationship to the director of the hospital.

NATIONAL GROUP WILL HELP

MRS. DIXON: Don't you feel that the national group, if it has a chart such as a successful individual hospital has, will be a real help to other auxiliaries?

MRS. DELAFIELD: It should help enormously. You cannot imagine how it would have facilitated the start of such organizations, for example, as ours if there ever had been an organization chart and a definite policy. When you are starting from scratch with something which really has not been experimented with before and which you know little about, it would certainly be a godsend to have something to go by.

MRS. DIXON: Smaller auxiliaries that have not realized they have been overstepping can learn from association with other people, or they can learn from an organization chart, or books and from other sources.

MISS JOHNSON: Yes, that is where the smaller hospital is going to get much help from a state organization of auxiliaries. It will be able to prove to its auxiliary that it has a place in the hospital but that it is limited to a certain function.

MRS. DELAFIELD: It is all the difference between doing things by trial and error, fighting your way through, and having someone tell you how it should be done through past experience.

MR. SLOAN: I think we are all agreed that we are for the state and national organizations. We are all 100 per cent for the women, too, aren't we? Within hospitals, and without!

DR. BROWN: Definitely.

Erie civic leaders shown mapping strategy for the St. Vincent's Hospital campaign are, left to right: D. Angus Currie, W. Humphrey Arbuckle, A. G. Tideswell, James B. Dwyer, and Lewis T. Briggs, general chairman.

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Hospital leaders, like army strategists, know that skilled, experienced direction often means the difference between failure and success.

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Under the direction of Ketchum, Inc., the public-spirited citizens of Erie organized industry, commerce, labor unions, civic groups, and the press and radio into a powerful, united civic movement. An inspired community responded generously to their appeal for funds. Employes of one company pledged $83,594 in addition to a gift of $150,000 by the firm itself. $100,000 was contributed by the Federation of Clubs of Erie.

A total of $1,359,365—23% over the goal—was subscribed in this campaign described by Board of Trustees President, George W. Bach, as "the outstanding campaign in the history of our city."

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GELATIN SOLUTIONS AS A PLASMA SUBSTITUTE

C. EVERETT KOOP, M.D.
Children's Hospital, Philadelphia

THE procurement of blood and plasma in adequate amounts for hospital use remains a problem in many institutions, but is of special importance in those hospitals with limited or no blood blank facilities. Recent advances in the preservation of blood have done much to ease this situation by enabling hospitals to store whole blood for longer periods of time than formerly. The ease of handling lyophylized plasma was also a forward step in making transfusion fluids readily available, but this has been somewhat offset by the fact that dried plasma is now known to carry the virus of homologous serum jaundice.

REASONS FOR TRANSFUSION

Although there are many functions of blood and plasma, transfusions of these materials are usually undertaken for two reasons only: to increase the blood volume and to increase the number of oxygen-carrying red blood cells. Because blood accomplishes both of these objectives, it is used in preference to plasma by most clinicians. When blood is not available, however, plasma provides an excellent means of increasing the blood volume, were it not for the danger of hepatitis. Solutions such as saline and glucose are rapidly lost from the circulation because they lack the colloidal osmotic pressure exerted by the proteins in plasma or blood and hence are of temporary benefit only as a replacement for loss of blood volume.

Since the early years of the first World War investigators have sought a substitute for plasma that would not require the use of donors, that would be effective as an infusion fluid in shock, and that would be safe for injection in large quantities. Many such substitutes satisfied two of these requirements but few have met all three.

The plasma substitute that presents the greatest promise and which has successfully met the test of clinical use is a solution of gelatin. Of the several varieties of gelatin which have been studied, one in particular (P-20) seemed to be superior because of the large average molecular size of its particles. This solution is stable, is easily stored without refrigeration, has a high osmotic pressure, and has a colloidal particle size large enough to be retained in the circulation for several days.

A 6 per cent solution in normal saline, this preparation is safe for injection in large quantities and does not interfere with blood coagulation, the defense against infection, tissue repair or with the function of internal organs. Immunologically, the material causes no sensitivity reactions and is not accompanied by other cross-allergic manifestations.

The chief use made of gelatin solutions in hospital practice is in the treatment and prevention of peripheral collapse or shock owing to blood loss. If the blood loss is great, then gelatin may be used as a temporary measure and should be followed by the infusion of whole blood when possible. When the blood loss is sufficient to depress the blood pressure and produce other signs of circulatory failure but not great enough seriously to interfere with oxygen transport, gelatin solutions alone suffice to replace the lost blood volume and correct vital signs.

When a falling blood pressure is expected, as in spinal anesthesia, or where an intravenous infusion is indicated and blood, for one reason or another, is difficult to procure, the infusion of gelatin adequately supports the patient during operation provided that the blood loss is not severe enough to depress the circulating red blood cells to a dangerous level.

In the emergency treatment of hemorrhage in the accident room, where major blood loss is unpredictable and frequently cannot be estimated, gelatin solutions provide a satisfactory means of treating the patient in shock. In most instances gelatin infusion alone restores the vital signs and in those cases in which blood loss is greater than one would care to treat without blood, gelatin serves as a temporary expedient while blood is being typed and cross-matched for eventual transfusion.

In the aged, in infants, or in those patients with limited cardiac reserve, gelatin solutions should be infused with the same caution used in the administration of blood or plasma because of the resulting increased plasma volume and the added load it places upon the heart. Gelatin solutions may be given in conjunction with blood, saline or glucose solutions without fear of reactions or incompatibility. After gelatin infusion the sedimentation rate of red blood cells is increased and rouleaux formation of red cells is pronounced but not sufficiently so to be confusing to the experienced technician in the cross-matching of blood for purposes of tranfusion.

SAFE AND INEXPENSIVE

Gelatin of the variety described provides a safe, effective, readily available, and inexpensive substitute for plasma for the common circumstances where one ordinarily would rely upon plasma. It is not intended to be a blood substitute, but just as infusions of electrolyte solutions in those with a failing peripheral circulation are better than no infusion at all, plasma solutions are better than electrolytes in the treatment of shock. Gelatin infusion provides the same response as one would expect with the use of plasma itself. Its ready availability and ease of administration enhance its value, especially when there is fear of jaundice following plasma infusion and when blood is not available. Even in hospitals where blood is easily obtained, the use of a gelatin infusion while waiting for blood typing and cross-matching is an added means of safety for the patient in need of circulatory support.

Contact

OF A SENSITIZED BODY CELL

with an allergen and subsequent release of histamine is considered to be the mechanism of allergic disorders.

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INTEGRATING THE GENERAL PRACTITIONER

CURTIS H. LOHR, M.D.
Superintendent and Medical Director, St. Louis County Hospital, Clayton, Mo.

THE integration of the general practitioner into the medical staff organization of our voluntary hospitals is an urgent and recognized need which continues to deserve the serious consideration of hospital administrators and boards of trustees. We have talked about it a lot but only a few of us have actually made a place for the general practitioner in our staff organization and activities.

It is the primary purpose of this presentation to urge more hospitals to take this badly needed step and to describe an established and proved method which will integrate the general practitioner into the staff organizations with benefits to all concerned.

DOING EVERYTHING POSSIBLE

As a secondary objective it is hoped that the general practitioners will come to realize that the hospitals are doing everything possible in their behalf and that the existing difficulties are basically not the fault of our hospitals but are the indirect result of the prevailing policies in medical education and practice with their ever increasing trend towards specialization. Whether right or wrong, these policies and trends are not determined by hospitals but arise from within and can only be corrected by the medical profession itself.

As a result of over-specialization and because of the general practitioner's failure to take an active part in organizational affairs, he has become an inarticulate minority in the planning of medical policies and he finds himself now in too many instances on the outside of the otherwise well integrated and coordinated staff systems of our hospitals. Fortunately, there are exceptions to this regrettable and unsatisfactory state of affairs. Some hospitals have provided a place for the general practitioner in their staff organizations and there is no valid reason why most of us cannot follow the example set by these progressive institutions.

The plan which will be proposed in subsequent paragraphs for the integration of the general practitioner into the staff organization of hospitals neither is new nor was it originated by me. It has been in effect in several large and representative voluntary general hospitals. It has been successful wherever it has been given a fair trial.

In brief the plan is as follows: As soon as the board of directors and the medical staff of the hospital have decided to integrate the general practitioner into the staff organization, the change in policy is effected by amending the constitution and the by-laws of the hospital with a provision creating a section on general practice in addition to the various specialty sections.

The amendment will define the scope of the activities of the new section on general practice, its relation to the staff as a whole and to the various specialty sections in particular.

Provision must then be made in the by-laws for the proper administration of the section by its own officers and committees and their election and duties must be prescribed. The chief of the section, who is elected by and from its members, will become a member of the staff's executive committee and will represent the section in the former's deliberations. The by-laws will also define the requirements and the procedure for appointment at various levels of staff rank, for promotion, and for disciplinary measures.

The next step requires the preparation by the hospital administrator, the medical director, and the executive committee of the indicated rules and regulations which will govern the work of the section on general practice. These regulations will define the standard of service to be rendered by this section to its patients, the requirements for stated ward and grand rounds, for consultation, adequate clinical records, x-ray and laboratory work, necropsies, C.P.C.'s, sectional administrative and scientific meetings, thorough monthly medical audits, history and journal club meetings, complete minutes of all meetings and conferences, attendance records and participation in teaching activities of the nurses, the auxiliary professional personnel and the house staff.

In reference to the last, the section of general practice can render invaluable service to the public, the medical profession, and the hospitals by organizing and conducting training facilities for those members of the house staff who desire to enter general practice and who wish to prepare themselves better for this work by one or two additional years of rotating hospital experience above the internship level.

PROVISION FOR ATTENDANCE

In order to assure proper standards in the work of the general practice section, the rules and regulations should include a provision for the attendance at its sectional meetings of carefully selected members of the various specialty sections. Their presence will afford constructive criticism and instruction and in this manner the general quality of the work of the section will be gradually raised to a higher quality level. The efforts of these consultants will exemplify the interest of the specialty sections in the development and the successful operation of the general practice section. Such

From a paper presented at the Clinical Congress of the American College of Surgeons, Los Angeles, 1948.

recognition and efforts will stimulate the general practitioner to improve himself and to take pride in the quality of his work.

The rules and regulations should also authorize and urge the members of the general practice section to attend the meetings, conferences and ward rounds of the specialty sections. Provisions should also be made to permit general practitioners who are interested in a particular specialty to improve their knowledge and ability in the specialty concerned by participating in its work under proper supervision and guidance and in keeping with their respective ability and professional development.

A provision should also be made to enable general practitioners who have assisted in the care of charity cases of specialty sections, who have made satisfactory progress and who have a sincere desire to limit themselves to the specialty in question to withdraw from the general practice section and to obtain appointment to the specialty section at a staff level commensurate with their achievements.

NOT SUCH AN EASY MATTER

Up to this point it appears that the integration of the general practice in the hospital staff is not a difficult matter and that it requires only a few changes in the constitution, by-laws and regulations of the hospital. Actually, it is not as easy as that and in the past most of the efforts to provide a place for the general practitioner in our staff organization have failed on account of the much more difficult second phase of the integration—the reconciliation of the demands of general practitioners to do major surgery with the strenuous objections of the surgeons to such concessions.

While it is difficult to adjust these differences of opinion and conflicting interests, they can be overcome in the formation of a section on general practice. In this manner the general practitioner can be assigned a definite place in the staff organization of the hospital without recognizing him officially as a specialist in surgery as would be the case if he were assigned to a specialty section of the staff. After the general practice section has been formed it should not be too difficult to induce the surgeons of the staff to approve the granting of operative privileges provided they are assured that this privilege will be limited to carefully selected members of the general practice section consistent with their individual training, experience and demonstrated skill.

After the surgeons have accepted these principles, it is of the utmost importance that adequate provisions be made in the rules and regulations for the definition of the basic qualifications upon which a claim for operating privileges may be based. It is likewise important to stress in these regulations that this privilege is not conferred automatically by mere appointment to the general practice section but that it is granted only on an individual basis to those members of the general practice section who have the prescribed basic qualifications and who, in addition, have demonstrated their competency to the satisfaction of a designated "observer" or "supervisor" appointed by the chief of the specialty section concerned during a prescribed probationary period.

The regulations will define how, when and for what length of time the "observer" will supervise the candidate in his work in order to determine his proficiency in the basic sciences, diagnosis, surgical technic, surgical judgment, self-recognition of limitations and sense of responsibility to patients, the staff and to the hospital.

MUST BE RESPECTED

The "observers" had best be senior members of the respective specialty section. They should be known and respected for their competency, fairness and for their interest and their ability in the teaching of younger men. Above all, these "observers" must be beyond reproach as to ethics and personal and selfish considerations. As soon as indicated the "observer" will report his findings and recommendations to the executive committee for its consideration and action. In submitting his recommendations the "observer" must define the extent to which the candidate may be granted operative privileges with or without continued supervision.

In fairness to all concerned, the rules and regulations should also provide a mechanism through which the recommendation of the "observer" may be appealed from either by the candidate or by other members of the staff. Such appeals should be considered by a designated appeal board appointed by the executive committee. The decision of the appeal board must be final.

Lest it might be claimed by general practitioners that the proposed period of probation and supervision is a further stigmatization of and discrimination against them and is therefore objectionable, let me point out that the described method of evaluating the proficiency of a general practitioner who is requesting surgical privileges is not new and not unfair. Quite to the contrary, it is equitable to all concerned with special emphasis on the surgical patient. Actually, the proposed method is the same which was in widespread use in good hospitals prior to the days of specialty boards and their prescribed and formal training. As a matter of fact, it is the same method which is used to this day by good hospitals in evaluating newcomers even though they are diplomates of specialty boards. The proposed probation and supervision of the general practitioner who requests surgical privileges are certainly no stigma or discrimination if they are also applied to and accepted by the diplomates of specialty boards.

SCRUTINIZE ALL SPECIALISTS

In discussing the need of evaluating the competency of the members of the general practice section who desire operative privileges, I cannot pass up the opportunity in my capacity as a superintendent and medical director of a general hospital who is also an internist to recommend that the scrutiny of qualifications be not limited to those applicants for appointment to the general practice section who wish to do major surgery but that it also be extended to those who will limit themselves to medical, pediatric and obstetrical cases. I must contend, with due respect to my surgical colleagues, that it is not only the surgical case who requires knowledge, experience and skill. The same requirements are needed in the proper treatment of a patient with pneumonia, typhoid fever, tularemia, tuberculosis, diabetes, coronary disease, eclampsia, pregnancy complicated by heart or kidney disease, or in the feeding problems of infants. If this contention is true then it would seem to be fully justifiable and even indicated to subject even those applicants who will limit themselves to medicine, pediatrics and obstetrics to an evaluation of their professional ability in

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• *Literature on request.*

1. Habel, J. M., Jr.: Va. Med. Monthly, October 1948.

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their chosen field during a prescribed probationary period.

Whether or not the provision for "observation" and/or probationary period is made all inclusive or is limited to those general practitioners who request surgical privileges, the fact remains that it affords a realistic approach to a difficult problem. It recognizes the fact that neither a certificate from a specialty board nor the verbal claims of training and experience submitted by a general practitioner are conclusive and permanent guarantees that either a specialist or a general practitioner applying for appointment to a hospital staff is a "safe" surgeon, internist, pediatrician or obstetrician, who will restrict his work in keeping with his limitations, will use good professional judgment and will be equal to his responsibilities to the patient, his colleagues and the hospital. I am sure that most of us can recall instances where it became necessary to apply restrictions not only to a general practitioner but to diplomates of specialty boards as well.

While this method of evaluating the qualifications of general practitioners to do safe major surgery is not easy in its application, it is imperative to the welfare of the patients and to the reputation of the hospital. It requires sincerity of purpose, courage, backbone and considerable work on the part of the observer and the executive committee and the administrator. It has merit in that it is eminently fair and protects the interests of all concerned. Wherever it has been properly applied it has overcome the greatest difficulty to the integration of the general practitioner in our hospital staffs and the general practitioner's bitterest complaint—restriction to nonsurgical cases.

The various provisions recommended in the preceding paragraphs constitute a workable and proved plan for the proper integration of the general practitioner into the organization and activities of our hospital staffs which is so badly needed. As we consider this plan we must remember that the general practitioner needs hospital facilities if he is to render optimum service to the community in which he works. If he does not have access to our institutions the usefulness of the general practitioner will continue to wane. Without an adequate number of competent general practitioners the struggle against the socialization of medicine and eventually of our voluntary hospitals will certainly be lost.

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Edema Formation in Heart Failure

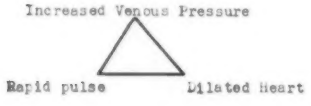
AS A result of the success in the battle against acute bacterial and viral diseases, a larger segment of our population is living into the age period where cardiovascular-renal disease becomes the major killer. Among the group of cardiovascular-renal diseases, cardiac decompensation, or heart failure, is extremely important in reference to both morbidity and mortality.

MECHANISMS IN HEART FAILURE: Heart failure may be caused by three general mechanisms:

1. Impaired filling (*e.g.* owing to cardiac tamponade).
2. Shock (*e.g.* owing to vasomotor collapse associated with coronary thrombosis).
3. Myocardial weakness (*e.g.* owing to valvular or myocardial damage).

Of the three, the factor of myocardial weakness is by far the commonest and will be discussed in greater detail.

Under normal conditions the heart complies with the metabolic demands of the body tissues by supplying them with blood containing oxygen and other nutrients. When the heart fails to meet its responsibilities, it is said to be in failure or to be decompensated. Heart failure leads to the following triad of pathophysiological events.

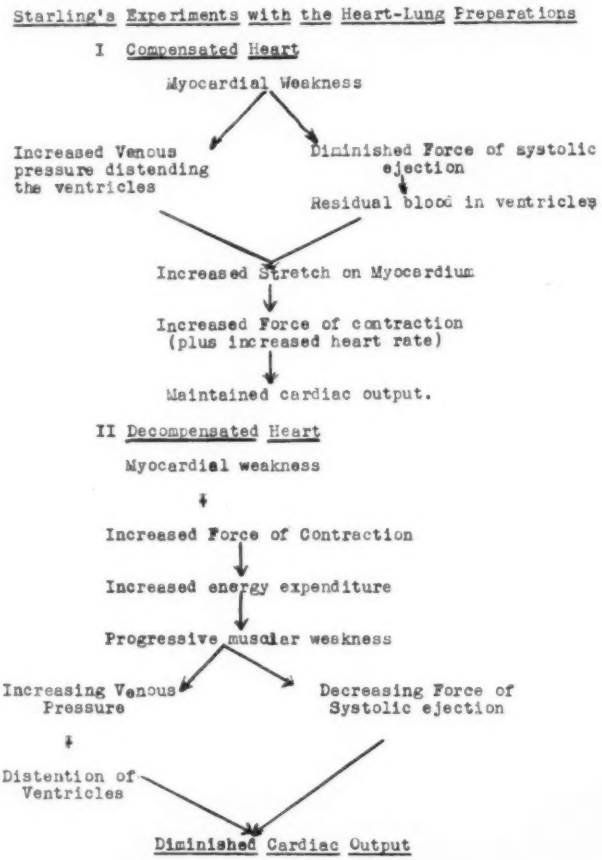


Starling's Law of the heart, published in 1914, states, "The law of the heart is therefore the same as that of skeletal muscle, namely, that the mechanical energy set free on passage from the resting to the contracted state depends on the area of 'chemically active surfaces,' *i.e.* on the length of the muscle fibers."

With myocardial weakness there is an associated increase in venous pressure and incomplete emptying of the ventricles. Usually these are thought of as being the *result* of the myocardial failure. On the other hand these can also be construed as *compensatory mechanisms* tending to increase the stretch on the heart muscle fibers and thereby increasing the forces of contraction in an attempt to maintain the cardiac output. This mechanism usually fails, however, inasmuch as the increased energy expenditure leads to further myocardial weakness and further decompensation. Starling's concepts may be schematically portrayed as shown below.

The cardiac output which the failing heart is valiantly trying to maintain is adjusted to the metabolic needs of the body. The output per minute is the product of the stroke volume (the amount of blood ejected per beat per ventricle) times the heart rate. Obviously, under basal conditions of rest, metabolic demands on the heart are much less than they are under conditions of active exercise. Thus physical rest with resultant decrease in metabolic needs is an important consideration in the treatment of heart failure.

THE MEASUREMENT OF CARDIAC OUTPUT: In the past, cardiac output has been determined by indirect gas or



dye methods. Recent developments in technic have permitted the application of the direct Fick principle in the calculation of cardiac output. The Fick principle, devised in 1840, states that:

$$\frac{\text{Oxygen consumption (cc./min.)}}{\text{Arterial-venous oxygen difference (cc./100cc.)}} = \text{Blood Flow (Cardiac Output)}$$

To illustrate the principle, let it be assumed that the body utilizes or consumes 360 cc. of oxygen according to its needs, leaving 14 cc./100 cc. in the venous blood flowing from the periphery back to the lungs. Since each 100 cc. portion of blood supplies 6 cc. of oxygen, how many 100 cc. portions would be required to supply the need of 360 cc. of oxygen every minute? Obviously 360 ÷ 6 would yield the number of 100 cc. portions required to supply the oxygen demand. Since each portion is 100 cc. in volume, the total blood flow pumped from the heart to supply the oxygen need would be:

$$\frac{360 \text{ cc./min.}}{6 \text{ cc./100 cc.}} \times 100 = 6000 \text{ cc. of blood (cardiac output per ventricle)}$$

It is technically quite simple to determine oxygen consumption by means of a B.M.R. machine. It is also simple to obtain an arterial blood sample by direct puncture of the brachial, radial or femoral artery. The fly in the ointment insofar as the clinical application of the Fick principle has been the securing of a *mixed venous blood* sample representative of venous blood from the entire body. Obviously, such a sample must come from the right atrium, right ventricle or pulmonary artery. To this end, in 1941, Cournand and his associates developed a catherization technic whereby in the unanesthetized patient a long, (100 cm.), plastic-coated catheter was threaded into the ante-cubital vein up the brachial vein into the superior venacava and down into the right heart. The catheter is radio-opaque and its course is followed by fluoroscopy. Aside from the injection of local anesthetic prior to the surgical exposure of ante-cubital vein, the patient feels no pain or any other sensation during the passage of the catheter. In expert hands the procedure is quite safe with no recorded mishaps in many thousands of catheterizations.

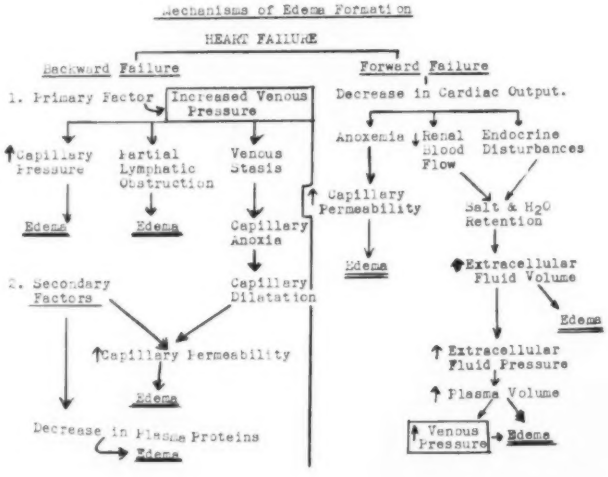
In this manner a truly mixed venous sample can be obtained and the direct Fick principle can be applied in the determination of cardiac output. Values obtained by this procedure are considerably higher than those obtained heretofore by indirect methods, *e.g.* 6.0 ± liters/min. by the direct Fick in contrast to 4.0 ± liters min. by the Grollmann acetylene method. In passing, it should be mentioned that the cardiac output is a most labile phenomenon and that the available methods do not yield a continuous recording of cardiac output. Catheterization experiments have also demonstrated the essential features of Starling's Law of the heart in reference to the right ventricle: the greater the pressure at the end of diastole, the greater is the pressure developed at the peak of the following systolic contraction.

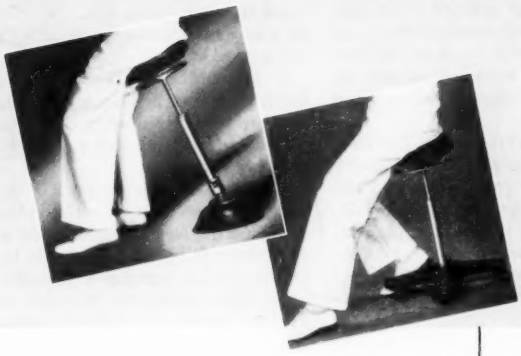
"BACKWARD" *vs.* "FORWARD" FAILURE: One of the earliest signs of heart failure is the insidious retention of water and electrolytes in the extracellular fluid compartment. The increase in interstitial fluid volume may first manifest itself in swelling of the ankles, a dependent edema which may subside on assuming the horizontal position. Increased moisture in the lungs impairs exchange of vital gases and leads to dyspnea or shortness of breath. Associated with an elevated venous pressure and an increased blood volume, there may be hepatomegaly, splenomegaly and/or ascites.

There are two opposing views on edema formation in cardiac decompensation. One postulates that edema is the result of an elevation of venous pressure owing to a damming back of the blood from the failing heart. This is the so-called "backward failure" theory. The other view postulates that edema is primarily due to the retention of sodium and water by inadequately functioning kidneys as a result of a diminished cardiac output. This is the so-called "forward failure" theory. The mechanisms of edema formation schematically portrayed by Davis and Smith (Am. J. Med. 3:704, 1947) are presented below.

The proponents of "backward failure" apply Starling's isolated heart-lung results to the failing circulation in man in a simple and direct manner. It is assumed that the right and left ventricles expel a given equal quantity of blood per systolic contraction. As a result of myocardial weakness or increased peripheral resistance, the output of the left ventricle is reduced. Since the inflow to the left ventricle remains unchanged, it receives more blood than it ejects. If the left heart retains just one drop of blood with each systole, in the course of one hour it would have retained approximately 360 cc. of blood! The retention of blood by the left ventricle causes dilatation and an increase in intra-ventricular, intra-arterial and pulmonary venous pressures. A similar series of events occurs with decompensation of the right ventricle leading to an elevation in peripheral venous pressures and edema formation.

In the "forward failure" scheme, it is the inadequate blood supply to the capillary endothelium, kidneys and endocrines (posterior pituitary, and adrenal cortex) that fires a series of





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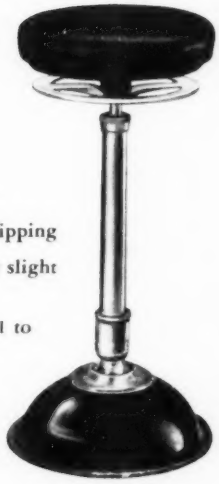

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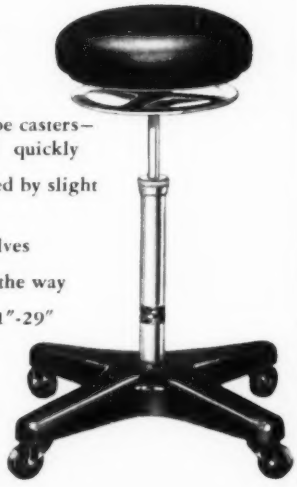

Mounted on swivel type casters—moves smoothly and quickly

Easily raised or lowered by slight finger pressure

Foam rubber seat revolves

Quickly moved out of the way

Range of elevation—21″-29″

If vacationing in New York State, visit our plant and see quality Ritter equipment manufactured.

ON A Ritter Stool...

Your staff can get more done with less effort sitting down. And the relief from strain may add as much as five years to a Doctor's professional life.

The Ritter Rest and Relief Stool enables the Doctor to incline his body to any desired position in relation to the patient. With the Mobilrest he can remain firmly seated, yet move quickly from the chair to other parts of the room in seconds. Once he sits down on a Ritter Stool, he'll never work again standing up. Your Ritter dealer will be glad to demonstrate these fine stools at the hospital, or send for stool literature, "To Get More Done with Less Effort."

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mechanisms resulting in edema. Considerable evidence has been marshaled in behalf of the thesis of "forward failure."

In many cases of cardiac decompensation it is possible by means of the catheterization technic to demonstrate a *decrease in cardiac output.* It has also been shown by the clearance procedures using inulin and para-aminohippuric acid that both the renal blood flow and glomerular filtration rate are reduced in heart failure. The normal average value for glomerular filtration rate is 130 cc./min. In heart failure the filtration rate falls below this level and edema ensues at or below 70 cc./min. In addition to clearance studies, it has been demonstrated by means of radiosodium tracer investigations that the body retains sodium during heart failure.

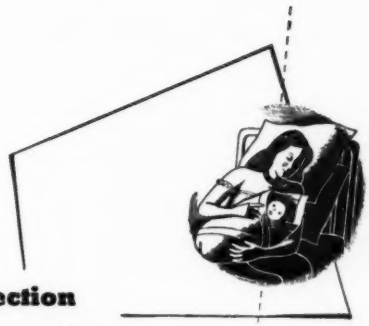
CARDIAC OUTPUT IN HEART FAILURE: The opponents of the "forward failure" school point to the fact that the cardiac output is not always decreased in heart failure. In fact, in some cases it may be *normal* or even *increased!* Careful investigation of this criticism has revealed that under specified conditions in cardiac decompensation the cardiac output may actually be low, within normal limits, or high as described below:

1. Low cardiac output: A decreased cardiac output occurs in many patients in heart failure even when the metabolic demands are minimal, *e.g.* at complete bed rest.

2. Normal cardiac output: Some patients maintain a normal cardiac output in the face of moderate metabolic demands, *e.g.* at rest or mild exercise; however, increases in the metabolic requirements, *e.g.* by moderate exercise, result in a drop in cardiac output.

3. High cardiac output: Under two diverse conditions, hyperthyroidism and anemia, the cardiac output during cardiac decompensation may actually be higher than normal. In both of these states a high cardiac output is required in the absence of heart failure. In hyperthyroidism the metabolic demand of the tissues is greatly increased because of endocrine disturbances. In anemia, owing to an insufficiency of oxygen carriers (red cells), the metabolic demand of the tissues can be satisfied only by an increased rate of flow. The heart, suffering from myocardial weakness, increases its cardiac output above normal limits in an attempt to supply the need. Owing to its weakness and the extra work load it cannot reach the level demanded by hyperthyroidism or anemia and fails even though its output is above normal.

Thus, the variability in cardiac output during decompensation is not a valid criticism of the "forward failure" thesis, since in all three conditions the cardiac output is unable to satisfy the metabolic demand. It can be said, however, that the "forward failure" theory does not fully explain all the phenomena occurring during cardiac decompensation, *e.g.* rapid changes in venous pressure following intravenous administration of digitoxin. As of the present the evidence is insufficient to explain completely all the mechanisms of heart failure and edema formation. It is probable that as cardiac decompensation begins, the phenomena of "backward failure" predominate but as congestive failure progresses, the factors of "forward failure" including salt and water retention assume major importance. Further work remains to be done to synthesize the two views into a satisfactory explanation of the mechanism of edema formation in heart failure.—J. H. LAST, Ph.D., M.D.



routine **protection**

against hemorrhage . . .

Synkayvite is a stable, potent, water-soluble vitamin K compound used to prevent bleeding in the newborn when due to hypoprothrombinemia. Vitamin K is now used during labor or at birth with "life saving effect."[1] Prothrombin levels can also be quickly restored in obstructive jaundice, gastrointestinal disorders and other conditions marked by bleeding tendencies due to vitamin K deficiency. Adult dosage, 5 to 10 mg daily, administered orally or parenterally, larger doses when necessary. In routine obstetrical use, 10 to 20 mg parenterally to the mother during labor, or 5 mg to infant immediately on delivery. Synkayvite is supplied in 5 mg tablets for oral administration, and in 5 mg and 10 mg ampuls for parenteral use.

1. *Wiswell, G. B., Canad. M.A.J.*, 53:555, 1945.

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Conducted by Mary P. Huddleson

COST ACCOUNTING FOR THE DIETARY DEPARTMENT

FERNE KING
Rochester Institute of Technology, Rochester, N.Y.

THE director of a hospital's dietary department is responsible for one of the largest single items of expense on the organization's budget, that is, service of food to patients, personnel and employes. In the majority of instances, the bookkeeping for the entire hospital is done in a central office and supplies are obtained through a central purchasing department. However, as a guide to intelligent day-to-day buying and future planning, the dietitian within her own department needs records for cost control. These should be set up so as to give her immediately at the end of an operating period needed information as to her costs without having to wait for the slower processes of the accountant's report.

Realizing that a hospital dietitian's day is a busy one, I do not wish to suggest a complicated and elaborate system of records which will be a burden to her, particularly when she has no clerical assistance. The most efficient method of control will usually be found to be the one which is the simplest, involving fewer forms to be filled out but giving the necessary information.

Purchase Order Record. Food used will fall into two main categories: that purchased for immediate consumption and those items issued from a storeroom. A record should be kept of food ordered, whether it is done by the dietitian herself or through the purchasing department. Obviously, this is for the purpose of checking against a possible mistake in the delivery. Invoices of goods received in the department must be checked at once and any errors corrected immediately.

Perpetual Inventory. When a departmental storeroom is maintained and stores are purchased directly by the dietitian, a perpetual inventory is suggested. This is time well spent, for through a perpetual inventory, systematically kept, there is constant knowledge of the stock on hand. A rule that should have rigid enforcement is that nothing moves off the shelf without an authorized requisition. At the end of each operating period an actual count, or physical inventory, of the stores in the house should be taken. A comparison is then made between the physical count and the card records in order to test the accuracy of the perpetual inventory.

Daily Cost Sheet. Perhaps the most valuable means for "keeping track" of costs and thereby keeping them under control is the daily cost sheet. This can be set up in the form which is the most easily handled for the individual organization. Forms can be duplicated or printed for this purpose; accounting working sheet pads can be purchased, or the data can be set up in a notebook, either bound or loose-leaf, which would be used solely for the daily summary.

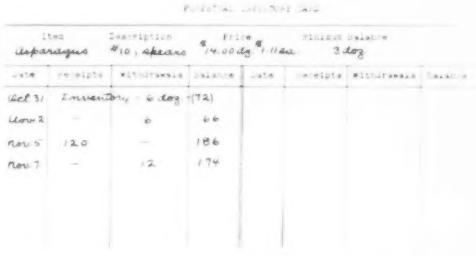
The illustrated form is merely a suggested breakdown for the classes of food which would be used in a day. It does give a quick method of analyzing the food dollar as to types of food purchased.

The figures are obtained from the checked invoices and storeroom requisitions. By dividing the total

Date

Quantity | Unit Price | Total Price

Signature



Item: Asparagus | Description: #10, 4 heads | Price: @ $4.00 doz @ 1 1/4 oz | Minimum Quantity: 3 doz

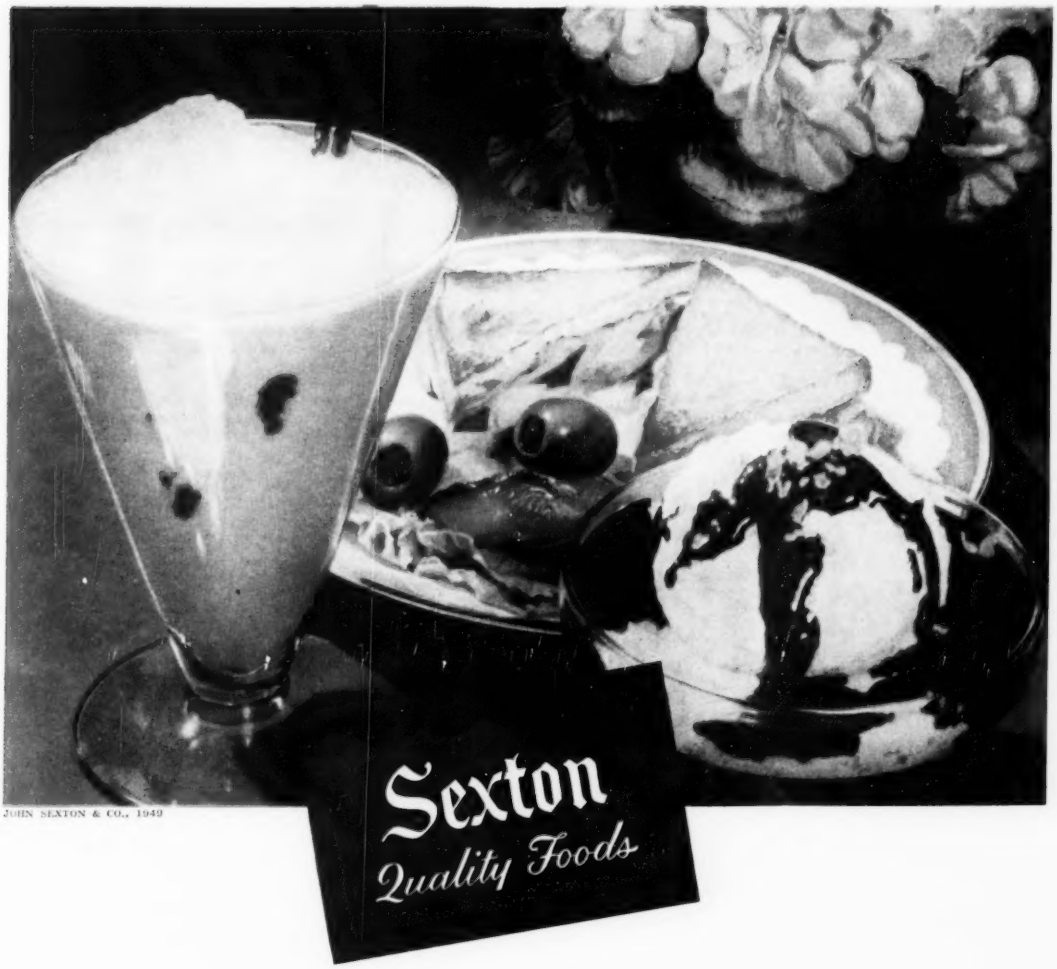
Date	Receipts	Withdrawals	Balance
Oct 31	Inventory	6 doz	4 (72)
Nov 2	—	6	66
Nov 5	120	—	186
Nov 7	—	12	174

The purchase memorandum provides a check against possible mistakes in delivery. The perpetual inventory card indicates the stock on hand.

Success...

Let Sexton fountain favorites win friends and influence profits for you. The smooth, mild, rich-bodied syrups . . . thick crushed fruits . . . toppings that are tops for taste . . . embody years of success in the art of tempting the public palate. Everything you need, ready for quick delivery to you. Ask the Sexton man.

Good Food for *Pleased Guests*



Hospital Viewpoint Influenced by New Facts on Costs of Electric Cooking!

ANOTHER STORY OF EXTRAORDINARY SAVINGS WITH *HOTPOINT ELECTRIC COOKING*—

from the Methodist-Episcopal Hospital, Indianapolis with 1,045 on the payroll, 645 beds, and 85 bassinets.

Here's fresh new evidence of the rapidly mounting trend to *electricity in commercial cooking*—more dramatic proof of the low cost of Hotpoint Electric Cooking. Methodist-Episcopal, one of America's outstanding progressive hospitals, installed Special Meters to measure electric cooking costs—to get them *scientifically* accurate—right down to a fraction of a penny. After months of careful checking, here is METERED-PROOF of the low cost of Hotpoint Electric Cooking at Methodist-Episcopal:

152 Watts, Per Meal, Per Person

(at a 2c rate, 152 watts would cost less than ⅓ of a penny, per meal, per person.)

But *this* saving is only part of the story. Methodist-Episcopal discovered that the even distribution of controlled heat with Hotpoint Electric Cooking cut food costs up to 20%. With the old-fashioned flame-type equipment, 5% of all meat was so badly seared it couldn't be used. Meat shrinkage and fat consumption were much greater. These losses changed to important savings with Hotpoint Electric Cooking.

Next, came cuts in labor and maintenance costs. Scouring and scrubbing, a constant high cost with flame-fuel cooking, was reduced to a minimum with CLEAN Hotpoint Electric Cooking—there are no products of combustion to accumulate on walls, ceilings, and utensils with Hotpoint Electric Cooking.

In addition to these money-saving advantages, the positive temperature controls of Hotpoint Electric Cooking permit a great variety of healthful, nourishing, appetizing foods—more appealing, more digestible foods with most of their nutritious juices and natural flavors retained.

Perhaps you, too, have felt the influence of facts like these pointing to the many advantages of Hotpoint Electric Cooking. Perhaps these advantages will end *your* search for greater economy and improved quality standards of the food *you serve*. Let the Hotpoint man bring you the complete story of Hotpoint Electric Cooking. Simply mail the handy coupon provided.

Hotpoint Electric Range with All-Purpose Oven. Selection of cooking top combinations to

Hotpoint 2-Deck Electric Oven with directional heat evenly distributed throughout

Hotpoint

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for outstanding achievement in engineering and design. 10th annual products design awards competition sponsored by Electrical Manufacturing Magazine.

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HOTPOINT INC., Commercial Cooking Equipment Dept.
229 S. Seeley Ave., Chicago 12, Ill.

Gentlemen: I'll talk to the Hotpoint man.

Name _____ Title _____

Hospital _____

Address _____

City _____ State _____

Salad dept. Date November 1, 194-

Item and Description	Amount	Unit Price	Total Price
Tomato Juice, #5 cans	2 doz	.31	7.44
Pineapple, #10 Unbeatables	1 Ca.	1.16	6.96
Strawberry Jam, #10	1 Ca	1.23	7.38
			$45.20

Signature

CAFETERIA DAILY REPORT Date November 5, 194-

Total Daily Receipts	$175.60
Total Cost of Food Used	86.50
Gross Profit	$89.10
Percentage of Food Cost: 49%	
Other Expenses	
Pay Roll (Estimated) 43.90	
Supplies 10.22	
Total Other Expenses	54.12
Net Profit	$34.98
(Gross Profit less Expenses)	

CAFETERIA MONTHLY REPORT

Total Receipts	$5625.00
Total Cost of Food Used	2875.75
Gross Profit	$2369.25
Pay Roll (actual) 1374.90	
Supplies 273.00	
Repairs & replacements 172.00	
Utilities (prorated) 55.00	
Total Expenses	1874.90
Net Profit	$494.35
Percentage Rate of Food Cost for Month	55.%
Percentage Rate of Profit for Month	.8%

cost of food by the number of persons fed in that day, the cost per person, or the per capita daily cost, is found. Further analysis can be made by providing space for the cost per patient per day. To find this one divides the total food cost by the number of patients rather than by the total number fed.

At this point, however, let me point out emphatically that a daily food cost report is of little benefit unless it is figured *every* day. A very small leak can be stopped if it is discovered immediately. The same small leak may turn into a flood if its presence is not detected. Keeping accurate daily records of expenditures trains one to keep a watchful eye on these small leaks.

You will notice that in the form for the daily food cost there is a column for "To Date" costs. This is found by adding the day's total to the previous "To Date" figure. There is a double reason for this. The first is that it enables the dietitian to see at a glance the total amount she has spent for food at any time during the month. The second is that the "To Date" figure on the last day of the month will be the total for the month. This eliminates the necessity of adding long columns of figures at the end of the month when analyzing the total costs for the period.

Nothing should be taken from the shelf without an authorized requisition, of which the form shown at left is an example. Right: Sample daily and monthly reports for the cafeteria.

Special Work at the End of the Month. The taking of the physical inventory at the end of the fiscal period has already been mentioned. It is now extended and its total value in dollars is determined. At this time, all food purchases are totaled and to this is added the inventory from the previous month. The sum of these two figures gives us the total amount of food which was available for use during the month. From this is subtracted the latest inventory. This gives the value of the goods actually used. The formula, well known to all accountants, is: "Purchases + Beginning Inventory — Ending Inventory = Cost of Goods Sold," or to fit our particular case it would be "Cost of Goods Used."

There will be some slight variation

DAILY RATION REPORT

Date	Meat, Fish & Poultry	Produce	Dairy Prod. & Eggs	Baked Goods	Store-room	Misc.	Total Cost Today	To Date	No. Fed	Per Capita	Daily Bills
Nov. 1	60.45	59.17	52.60	11.73	45.20	6.14	235.29	—	300	.784	
" 2	58.90	49.80	55.86	9.72	87.65	8.22	220.15	455.44	312	.705	
" 3	53.60	52.89	56.40	8.53	42.57	7.60	221.59	677.03	305		250.40
" 4	52.90	53.64	53.75	9.64	35.40	8.74	214.07	891.10	302	.918	208.65
" 5	63.87	45.70	52.19	11.86	37.42	6.97	218.01	1109.11		.709	217.80
										.716	214.94
" 30	67.82	43.28	51.65	10.60	35.16	7.48	215.99	7437.61		.725	194.65
Totals	$1747.00	$586.70	$1692.00	$289.20	$1129.50	$209.10	$7653.50	7653.50	9,876	.708	321.56
								$7659.50			$7987.60
								Add, Inventory, Nov. 1			854.92
											8842.52
								Subtract, Inventory, Nov. 30			1185.49
											7657.03
								Subtract, additional income			125.55
								Net Food Cost			$7531.48

The important thing to remember about the daily food cost report is that it must be kept accurately and every day. Otherwise, the small leaks may go unnoticed until the losses grow to big proportions.

here between the total figure for daily food costs and the total of the food invoices as will be recorded on the books in the main office. For example, the invoice for a large order of canned goods would appear in the total of the invoices for the month. What would appear on the daily cost sheet would simply be what had been issued from the storeroom for that one day's use. The total of the invoices is the figure to be adjusted with the two inventories.

Additional Adjustments. The hospital dietary department operates on an allotted sum of money, the budget. The amounts that are being spent are never seen actually by the person who is doing the spending. There are additional sources of income which, although minor, are too much to be overlooked. Credit should be given to the department for any food that has been purchased for activities outside the daily routine, such as refreshments for social functions. Another source of income would be from the sale of kitchen by-products, such as used grease, bones and garbage. Inasmuch as there is often no actual exchange of cash, these items would be treated at the end of the month as a deduction from cost.

Petty Cash Fund. As a matter of convenience in purchasing small items, whether food or supplies, a limited amount of cash should be turned over to the dietitian. It is usually a good policy to define in terms of dollars and cents what constitutes a petty cash expenditure. Signed receipts for payment on all articles purchased this way should be kept and turned into the office for replenishment of the fund. In keeping the daily cost, these expenditures would be placed in the appropriate column.

Monthly Reports. A periodic report to the administration must possess definite qualities. First, it should be brief: a busy administrator appreciates not having to plow his way through reams of paper. Next, it should be complete with regard to pertinent statistics. What was the actual cost of operating the dietary department? Here, figures as to cost of supplies and pay roll costs as well as food costs should be shown. What interests the executive is the result of the operations which the net figures should show. However, should he want to see how the dietitian arrived at her results, the routine records can be produced to substantiate the condensed report.

A brief yet complete report would contain the following information:

1. The net cost of food, after inventory adjustments and deductions have been made.
2. The number of meals served in that month, broken down into patient, personnel and employe meals.
3. The cost per meal and per day for patients and others.
4. Expenditure for supplies: paper, cleaning supplies, and so forth.
5. Pay roll expense.
6. Repairs and replacements.
7. Total of all items of expense in the department.
8. Per capita expense.

Pay Cafeterias. It will be well in passing to mention something about records for pay cafeterias for personnel and employes. Since money or tickets are directly received in exchange for food served, a separate report will be issued every day and filed in the dietitian's office. Food and supplies will be ordered from the main kitchen and these requisitions will be priced and extended daily.

(*Continued on Page* 104.)

HOW DOES YOUR FOOD GET UP TO THE ROOMS?

How does *your* food stand the trip from the time it's prepared until the time—usually much later—when it's served in the rooms?

Is it the same flavorful, appetizing food that came out of your ovens perhaps an hour or more before? Probably not.

Flavor loss has always been taken for granted in most places, due to the difficult circumstances in which food must be served. It shouldn't be. Flavor loss *can* be cut to a minimum today. There's a way to do it.

Try Ac'cent. Ac'cent, by intensifying the flavors you put into your foods, makes food taste better *longer*. This is being proved every day in hospitals and institutions—wherever the serving of food is complicated by *long waiting periods*.

You can try Ac'cent easily, quickly. And you can judge for yourself what it can do.

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FACTS ABOUT Accent

Ac'cent adds no flavor, aroma, or color of its own. A natural food-product itself, Ac'cent brings up natural food flavors. It helps in the preparation of nutritious dishes which have appetite appeal.

Ac'cent improves the taste of bland diets. Cooking helps to blur the raw, sharp profiles of many foods. Ac'cent helps further by emphasizing the desirable flavors.

Ac'cent helps solve the "leftover" problem. The tastier foods prepared with Ac'cent mean fewer leftovers. Also, Ac'cent in the original cooking gives the leftovers a better, fresher flavor.

Ac'cent helps preserve flavors. It combats "steam table fatigue", helps hold flavors for longer periods.

Ac'cent is economical to use. A little Ac'cent goes a long way in large quantity cooking. Directions are explicit.

Ac'cent is easy to control. The amount of Ac'cent called for is weighed before application unless only a small amount is required.

Ac'cent presents no storage problem. Ac'cent is physically stable under normal conditions, is less hygroscopic than salt, is packaged in containers that give maximum protection.

Accent®... makes food flavors sing

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Accent invites your inquiries

Our staff, long experienced in food preparation and thoroughly acquainted with the nature and application of this unique product, will welcome the opportunity to discuss its interesting possibilities in your operations.

In 1 lb. and 10 lb. cans and 100 lb. drums

Not a flavoring!
Not a condiment!
Not an ordinary seasoning!

Accent is MONO SODIUM GLUTAMATE

. . . over 99% pure, unadulterated, sparkling-white crystals. It is a natural, not a "synthetic" product. It is the sodium salt of the amino acid, glutamic acid, which occurs naturally in all vegetable and animal protein. Ac'cent is wholesome and good.

Illustrations on page 101 are of the daily report and of the monthly report.

Annual Report. The annual report will be a summary of all the expenses incurred by the dietary department during the year. In order to make financial plans for an ensuing year's operations, some knowledge must be had of expenditures for the current year, or the year immediately past.

The function of the hospital's nutrition department is not to show a profit but to keep the expenses within a stipulated amount and to serve the most nutritious and palatable meals possible for that amount. If a dietitian feels that she needs more money for the successful operation of her department, she must be able to present adequate reasons for her request. Nothing can be more convincing than a group of financial records, systematically and efficiently maintained.

FOOD FOR THOUGHT

Paper Cups Simplify Service

Rising labor costs have brought home the inefficient nature of many essential hospital food services to dietitians who are struggling on fixed budgets. A prime example is the service of nourishments to bedside, which requires a great deal of miscellaneous labor. In most hospitals, between-meal nourishments of orange juice or milk mean off-hour duties for the kitchen staff or an extra job for the overloaded pantry maid or nurse's aide who presides over the floor pantry.

In factories, where production-minded engineers face the same problem, the service of snacks to workers who cannot leave their jobs has been simplified by the use of mobile carts. Their experience can profitably be applied to the service of hospital nourishments.

Enough liquid nourishment for all those to be served may be prepared in the main kitchen and poured into one or more stainless steel tanks with faucet outlets. The tanks are then fitted into an inexpensive wooden cart equipped with dispensers of paper cups. A nurse's aide or kitchen employe rolls the cart directly from the main food preparation center to bedside, drawing off a portion for each patient as desired. If the patient wants a refill, the cart is near enough to make a second helping easy. If he does not feel like a nourishment, labor and food are not wasted. Patients discard their cups into their own wastepaper baskets after use.

When the aide has visited the last patient on her route, the chore of nourishment service is finished. She need not return to pick up dirty glasses, and no one need be kept on duty in the kitchen or pantry to wash them up. The hospital's stock of glasses can be kept in the main kitchen, where loss and breakage are lower than when it is stored in local service units.

Tests made by Mary Thomas of the Hackensack Hospital, Hackensack, N.J., on service of medicaments in paper cups suggest that hospital patients readily accept paper service. They appreciate the assurance that no other patient can have used the cup.

What food inset arrangement

DO YOU NEED?

One Conveyor Now Gives You a Wide Variety of Combinations for Your Selective Menus

● The top deck arrangements shown here are only a few of the many variations possible with the Blickman "Selective Menu" Food Conveyor. Eighteen square and rectangular insets are furnished in six different sizes. Variations in arrangement can be made to suit your specific needs simply by inserting the combination of insets you require. Your "selective menu" system can work smoothly and efficiently with this modern food conveyor. You can now offer your patients a great variety of meats, fish and vegetables, always kitchen-fresh and palatable. Two conventional round utensils provide for soup and broth. Two heated drawers provide for eight additional special diets. Blickman-Built food conveyors are made of enduring, sanitary stainless steel. It is the only standard truck made with a one-piece, crevice-free body and sanitary, seamless top deck construction. Consult us about your "selective menu" problems.

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explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.

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Visit our Booth at the Mid-Atlantic Hospital Convention in Atlantic City, May 18-20.

Menus for June 1949

Robbie Partain Bohlen
City Hospital
Fayetteville, Ark.

1 Applesauce Grilled Bacon, Toast • Stuffed Peppers Creamed Potatoes Buttered Carrots Spring Salad, French Dressing Devil's Food Cake • Vegetable Soup Chicken Croquettes With Mushroom Sauce Baked Potatoes Ice Cream Cookies	**2** Tomato Juice Poached Egg on Toast • Beef Roast Mashed Potatoes With Gravy Fresh Asparagus Beet Salad Baked Apple • Chicken Noodle Soup Club Sandwich Sweet Pickles Strawberry Shortcake With Whipped Cream	**3** Prunes Coffee Cake • Fried Perch Parsley Potatoes Green Beans Coleslaw Cherry Pie • Cream of Tomato Soup Tuna Salad Hot Rolls Olives and Pickles Washington Cream Pie	**4** Fresh Strawberries Soft Cooked Egg • Meat Loaf Escalloped Potatoes Fresh Spinach Fresh Cucumber Salad, Oil and Vinegar Dressing Grapenut Custard • Cream of Mushroom Soup Cheese Omelet Sliced Tomatoes Lemon Chiffon Pie	**5** Chilled Grapefruit Scrambled Eggs, Toast • Broiled Veal Chops Mashed Potatoes With Gravy Fresh Peas Radish Roses, Ripe Olives Strawberry Shortcake With Whipped Cream • Royal Cheese Soup Bacon and Tomato Sandwiches Lettuce Salad Chocolate Tapioca	**6** Pineapple Juice Pancakes and Sirup • Chicken Croquettes Baked Potatoes Broccoli With Hollandaise Sauce Tomato and Sliced Egg Salad Ice Cream Macaroons • Celery Broth Curried Lamb on Rice Tossed Vegetable Salad Raspberry Gelatin With Whipped Cream
7 Oranges Soft Boiled Egg • Baked Ham, Raisin Sauce Glazed Sweet Potatoes Buttered Cauliflower Lettuce and Tomato Salad Pineapple Sherbet • Cream of Asparagus Soup Corn Fritters, Sirup Crisp Bacon Fresh Fruit Salad Rice Pudding	**8** Prunes Sausage Links • Liver Mashed Potatoes Green Beans Sliced Cucumber Salad, Oil and Vinegar Dressing Whipped Orange Gelatin, Custard Sauce • Vegetable Rice Soup Liverwurst and Cheese Sandwiches Coleslaw Fresh Strawberries and Cream	**9** Grapefruit French Toast, Honey • Beef and Vegetable Pie With Hot Biscuits Jellied Lemon, Grapefruit and Cottage Cheese Salad Celery Hearts Spice Cake • Cream of Celery Soup Sliced Ham Potato Salad Pickles Chocolate Blancmange	**10** Orange Juice Poached Egg • Broiled Mackerel Mashed Potatoes Buttered Asparagus Coleslaw Fresh Boysenberries With Cream • Cream of Spinach Soup Shrimp and Tomato Salad Hot Rolls Congealed Fruit Cookies	**11** Baked Apple Scrambled Eggs • Broiled Hamburger Patties Mashed Potatoes Broiled Tomatoes Spinach Salad, Chiffonade Dressing Sponge Cake • Beef and Vegetable Soup Potato Salad With Cold Meats Carrot Curls Apple Pie and Cheese	**12** Fresh Strawberries Grilled Bacon, Toast • Fried Chicken Mashed Potatoes With Gravy Frenched Green Beans Tomato and Watercress Salad, French Dressing Ice Cream • Scotch Broth Creole Eggs Tossed Vegetable Salad Rhubarb Betty
13 Apple Juice French Toast, Honey • Braised Liver Mashed Potatoes With Gravy Buttered Beets Celery Sticks Baked Bread Pudding • Chicken Gumbo Grilled Frankfurters on Buns Pickle Relish Chef's Salad Strawberry Shortcake	**14** Fresh Peaches, Cream Shirred Eggs, Toast • Pork Roast, Applesauce Baked Sweet Potatoes Buttered Cauliflower Pineapple and Cottage Cheese Salad Ice Cream With Raspberry Sauce • Spaghetti With Meat Sauce Cabbage Slaw French Bread Cherry Upside-Down Cake	**15** Applesauce Grilled Sausage Links • Chicken and Dumplings Cranberry Sauce Green Peas Tossed Vegetable Salad, Oil and Vinegar Dressing Blueberry Pie • Salisbury Steak Lyonnaise Potatoes Lettuce Wedge, Cucumber Dressing Fresh Peach Shortcake	**16** Orange Juice Scrambled Eggs, Toast • Meat Pie With Mashed Potato Topping Tossed Vegetable Salad, Italian Dressing Gingerbread, Whipped Cream • Bacon Strips Fresh Black-Eyed Peas Fresh Spinach Corn Sticks Baked Apple	**17** Blended Juice Pancakes and Sirup • Salmon Loaf, Mushroom Sauce Parsley Potatoes Buttered Broccoli Fresh Fruit Salad Baked Fudge Pudding • Baked Shrimp and Cheese Delight Baked Potatoes Lettuce Salad, Thousand Island Dressing Sponge Cake	**18** Tomato Juice Grilled Bacon, Toast • Roast Veal Shoulder French Fried Eggplant Green Beans Shredded Lettuce Graham Cracker Pudding • Chicken Chow Mein Crisp Noodles Fresh Spinach and Egg Salad French Bread Applesauce
19 Bananas Poached Egg on Toast • Baked Ham Mashed Potatoes Fresh Lima Beans Stuffed Tomato Salad Cottage Pudding With Sliced Peaches • Cream of Tomato Soup Assorted Sandwiches Deviled Eggs Celery, Carrot Curls, Radish Roses Prune Whip	**20** Fruit Nectar Sausage Links, Toast • Braised Short Ribs of Beef Browned Potatoes New Beets Sliced Cucumbers Baked Apple • Cream of Spinach Soup Hamburgers Potato Salad Pickles Fresh Peaches Oatmeal Cookies	**21** Cantaloupe Boiled Egg, Toast • Curry of Chicken Duchess Potatoes Corn on the Cob Radish Roses, Celery Sticks Coconut Graham Cracker Pudding • Cream of Corn Soup Sausage Patties Apple Rings Baked Potatoes Asparagus Tip Salad Boysenberry Shortcake	**22** Tomato Juice Toast and Jelly • Veal Birds Succotash Cabbage With Lemon Butter Waldorf Salad Peach Shortcake • French Onion Soup Ham Escalloped Eggplant Sliced Potato Salad Toll House Cookies	**23** Orange Juice Scrambled Eggs, Toast • Swiss Steak Mashed Potatoes Wax Beans Lettuce, Thousand Island Dressing Chocolate Ice Cream • Individual Chicken Pies Hot Biscuits Tossed Vegetable Salad French Dressing Fruit Gelatin	**24** Grapefruit Juice French Toast, Honey • Fried Trout With Lemon Slices Creamed New Potatoes Garden Peas Stuffed Celery Boysenberry Shortcake • Cream of Mushroom Soup Tomato Stuffed With Tuna Salad Potato Chips Peach Ice Cream
25 Stewed Prunes Coffee Cake • Braised Liver and Onions Escalloped Potatoes Green Beans Lettuce Salad, Oil Dressing Rhubarb Betty • Hamburgers on Buns Stuffed Baked Potatoes Sliced Tomatoes Orange Sherbet	**26** Pineapple Juice Baked Eggs, Muffins • Baked Hen With Bread Stuffing Mashed Potatoes With Gravy Escalloped Squash Stuffed Celery Lime Sherbet • Deviled Eggs Cottage Cheese Peanut Butter and Jelly Sandwiches Pickles Sponge Cake	**27** Applesauce Bacon, Raisin Toast • Hamburger Roll With Mushroom Sauce Parsley Potatoes Cabbage au Gratin Sliced Tomato and Onion Salad Chocolate Tapioca • Cold Cuts Potato Salad Sliced Beets Hard Rolls Pineapple Bavarian Cream	**28** Apricot Nectar Soft Boiled Egg, Toast • Braised Beef Cubes With Noodles Fresh Spinach Spiced Pearh, Cottage Cheese Salad Creamy Rice Pudding • Italian Spaghetti With Meat Balls Tossed Vegetable Salad French Bread Devil's Food Cake	**29** Baked Apple Sausage Links, Toast • Baked Hen With Bread Stuffing Wax Beans Piquant Hearts of Celery Gelatin Cubes, Custard Sauce • Cream of Tomato Soup Cheese Fondue Lettuce Wedge, Thousand Island Dressing Apple Pie	**30** Cantaloupe Scrambled Eggs • Lamb Roast With Gravy Parsley Potatoes Garden Peas Minted Fruit Salad Raspberry Sherbet • Vegetable Soup Liverwurst and Cheese Sandwiches on Rye Bread Fresh Spinach and Hard Boiled Egg Salad Fruit Gelatin With Whipped Cream

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THE SECRET OF SUCCESSFUL AIR CONDITIONING

T. W. REYNOLDS
Chief, Air Conditioning Division
Abbott, Merkt and Company
Consulting Engineers
New York City

WHEN we think of a hospital we are likely to think of it as a place where people go to rest, relax and be quiet while being cured of ailments, yet here we also have, or should have, a business institution organized for specific purposes. In either case, the organization must function in the most efficient manner.

Safeguarding the rapidly increasing investment in hospital air conditioning is therefore of utmost importance. Performance must be the best, yet it must also be practical and economical, with economic considerations that differ materially from those of the usual commercial installations. Comfort and relief are so paramount in the hospital that any substantial diffusion of air with discomfort renders the entire air conditioning system null and void, regardless of how expensive it may be. There is no better way of accomplishing the desired result of good air conditioning than by using accepted devices which employ not only the most scientific but also the most sanitary methods of air distribution.

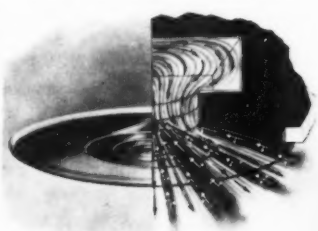
What Should Be Air Conditioned? Air conditioning in hospitals may be for comfort, with or without special functions, or it may aid in the treatment of diseases; however, for complete satisfaction, the entire hospital should be air conditioned, thus avoiding controversial problems with patients and doctors, such as occur when a patient is moved from an air conditioned space to one that is not.

When complete air conditioning is not practical, a planned program should be adopted. Consideration should be given first to the operating rooms and then the delivery rooms, nurseries and some of the patients' rooms. Air conditioning of public spaces and administrative departments and laboratories should follow, as well as conditioning of any chambers for storage of serum, vaccine or food. In anticipation of all such needs, a central refrigeration plant with cold water circuit should be provided and then sized and arranged so that future extensions can easily be made. A central system, unit system or a combination of the two should be carefully studied.

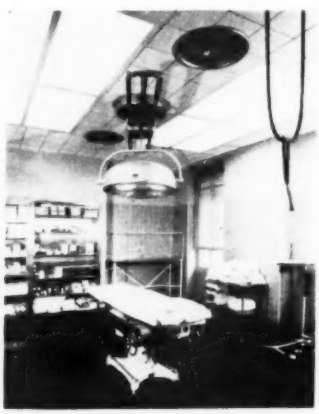
Complete air conditioning will be found in only a few hospitals, though air conditioning in one or more departments will be found in many hospitals. A hospital may be able and willing to comfort-condition some rooms, such as private rooms and general wards, but it may not be in a position to condition offices and public spaces. Zoning, therefore, is necessary, and consequently air conditioning equipment should be designed on the basis of performance specifications that call for definite results in each zone.

Costs. Installation costs vary considerably with location, type of building, exposures, construction and type of system. The cost for a unit of two operating rooms with sterilizing room between is usually from $4000 to $8000, while private rooms equipped with individual room coolers can be conditioned for from $400 to $600 per room and when a number of rooms are conditioned from central apparatus, the cost will be somewhat less.

Draftless Air Outlets. Drafts should be avoided and temperatures should be closely equalized regardless of the nature of the air conditioned space. Such conditions of comfort are greatly influenced by the type and location of the supply outlets and the location of the return grilles. It has been well established that for greatest comfort the velocity of air should be reduced within a supply outlet and then, and only then, allowed to enter the conditioned space. Such a method or equipment design ensures draftless air distribution, together with close tem-



Center: In-coming air (black arrows) siphons a series of counter-currents of room air (white arrows) back into metal cones. Left and right: Ceiling diffusers used in operating room of Hartford Hospital.



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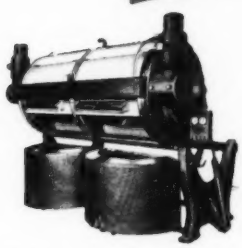

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Cuts down pulling time and labor costs – cylinder raises hydraulically to deposit loads into extractor basket halve Faster operation – more loads per day – saves floor space. 42-inch cylinder.

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Reduces time and labor formerly needed for loading and pulling. Loaded basket halves carried by electric hoist (from washer) quickly lowered into this extractor, then raised for dump-out at finishing tables.

AUTOMATIC WASHER CONTROLS

Conserve linen – as well as water, soap and other supplies – by precise formula control. Fully automatic models give exact, measured injection of supplies for any one of several predetermined formulas you select. No "over" or "under" runs, or amounts of soap, bleach, sour, blue, water and other supplies. Available with supply stand (for one washer) or with central supply system serving many washers.

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perature and humidity equalization. Savings in initial costs and operating expenses also result.

Supply outlets which cannot accomplish such desirable results must have their discharge velocity greatly reduced in order to overcome annoying drafts. Furthermore, they must be located so that their air stream does not discharge directly into any space that will be occupied by patients, doctors or nurses. This is not always easy to accomplish. In any event, such outlets do not give speedy and thorough mixing of the supply air with the room air.

A good air diffuser can distribute air evenly in a draftless pattern. How this can be accomplished is more readily understood by following the flow of air through such a device. As shown in the cross-section, air enters a conditioned space by first passing through the series of metal cones comprising the air diffuser. Air is instantly reduced in velocity within the cones because of their scientific design. Simultaneously, a controlled portion of the room air is siphoned into the air diffuser, where it mixes with incoming air from the duct. The premixed air then leaves the diffuser in a low-velocity pattern and settles in a slowly moving "pressure blanket" on the room air below.

Sanitation as a By-Product of an Air Outlet. All of the diffusion and air mixing action takes place within this diffuser, all air turbulence being limited to its immediate vicinity near the ceiling. Therefore, no drafts are perceptible to occupants of a conditioned space; furthermore, the air settles too slowly to create any circulation of infectious dust. As the primary air motion—of low velocity—is from the ceiling to the floor, the recirculation of polluted air is reduced to a minimum, particularly where there are exhaust outlets and these are duly equipped with back draft dampers. As a final measure of sanitation, the air diffuser contains no moving parts and owing to flush mounting provides no area in which dust can settle.

The Explosion Hazard. The application of air conditioning to operating rooms, recovery wards, delivery rooms and wards for communicable diseases has made great progress in recent years. Such applications not only serve to promote human comfort but also afford specific therapeutic and safety values. For example, in the air conditioning of operating rooms, it is considered necessary not only to create optimum conditions for the patients and attendants, but also to reduce the hazard of explosion of anesthetic gases.

The official 1948 "Heating, Ventilating and Air Conditioning Guide" says:

"Explosion hazards in operating rooms began with the introduction of modern anesthetic gases and apparatus. Ether administered by the old drop method gives rise to an explosive mixture, but in practice this method is still regarded as comparatively safe. When ether is mixed with pure oxygen, or nitrous oxide in certain concentrations, the explosion hazard may be as great as with ethylene-oxygen, or cyclopropane-oxygen mixtures.

"Of the anesthetic gases nitrous oxide alone does not explode but supports combustion. Ether, vinyl ether ethylene and cyclopropane are as potentially dangerous as is gasoline or illuminating gas in the home. Chloroform does not explode violently in contact with flame but decomposes to liberate phosgene. All of the anesthetic gases and vapors except ethylene are heavier than air. Although the incidence of injury or death from explosion is negligible compared with other hazards in operating rooms, the dramatic features surrounding an explosion justify continued investigation to eliminate the hazard. In any event, windows should be kept closed so that the air conditioning system can prevent pooling of anesthetic gases. Twelve air changes per hour and a humidity of 55 per cent are advised.

"The Operating Room. The severe physiological effects (such as excessive sweating and rapid pulse) of high operating room temperatures on attendants and patients during the hot months signify the need for proper cooling. A comparison of the statements of surgeons who operate in both air conditioned and nonair conditioned rooms strongly indicates that the recuperative power of the patient is greater when he is operated upon in air conditioned rooms. In the control of airborne infection in the operating room the prevention of dispersal of infectious materials into the air, control of dust, and proper ventilation supersede attempts to remove or kill pathogenic organisms. The bacterial content of conditioned operating rooms is generally lower than that of nonconditioned rooms."

Air Conditioning for the Nursery. Air conditioning is now considered absolutely necessary in nurseries, especially in those for premature infants. The stabilization of the body temperature of the infant is essential because the infant's body heat regulating system is not fully developed. The optimum conditions of these rooms vary widely according to the constitutional state and weight of the infant. It has been found that a temperature of 77° F. and 65 per cent relative humidity is generally satisfactory.

Air conditioning as an adjunct in the treatment of diseases is already successfully used in cases of allergic disorders and in cold therapy and will become more important. Considerable research regarding the influence of air conditioning on a wide variety of diseases, such as pneumonia, tuberculosis, arthritis and nervous instability, is also in progress. The results of this research will be of great value not only to the physician but also to the air conditioning engineer.

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The Sip Test. A big trade depends on a tiny sip . . . and tea companies pay high salaries to men just to sip or sniff. Accurately, the sensitive palates of these tasters can always tell tea at its best.

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When a one coat job is all that is necessary to make the interior of a building look like new, what paint will do the job best? Don't guess. Test! Compare any good paint with Barreled Sunlight. Paint a few square feet with each, side by side on a wall. The next morning, when the paint is dry, your eye will plainly tell you that Barreled Sunlight covers better. Yes, and *Barreled Sunlight will last longer, will stay fresh-looking longer, will cost you less for both PAINT AND LABOR than any other paint on the market.*

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What the Housekeeper Should Know About PURCHASING

VINCENT W. GODLESKY
Purchasing Agent
Beth Israel Hospital, Boston

QUANTITY FACTORS IN BUYING

THE next decision a buyer has to make, after having selected the right quality of merchandise, is to determine the proper quantity to purchase. Inasmuch as purchases are made to meet a need, the total quantity is basically determined by the nature of that need, whether for a specific project where the quantity required is definitely known, or for continuous operation, in which case it is classified as for stock or inventory.

When buying for a specific need, there is little or no problem as to quantity, but in buying for continuous operation one has to rely primarily on judgment, experience and intuition. Most requirements, however, can be forecast with a fair degree of accuracy on the basis of current and anticipated business and on records of past experience.

STORAGE SPACE A PROBLEM

The problem that is commonest to institutions in connection with quantity purchases is limited and insufficient storage space. Even though we are not large volume buyers, opportunities do arise through which we could reduce the unit cost of some items and assure ourselves of a steady supply if we only had the space to accommodate a large purchase at a quantity discount. Quantity discounts are among the most obvious of the elements which tend to reduce unit costs as the size of the order increases. They are usually granted on the theory that the purchase of larger lots will reduce the manufacturing and distributing costs of the supplier.

Generally, they are expressed in terms of a series of different prices which apply to quantity purchases within specified ranges. This series of different prices is an important factor for the buyer to be constantly aware of when faced with the problem of determining the most economical purchase quantity.

Although you may not be able to take advantage of a 100 case price, owing to space limitations, you might effect some economy by ordering another quantity that you can accommodate and on which there is a price differential in your favor. For example, many companies have a graduated price schedule for specified quantities, such as a price for one case, a lower price for ten cases, and so on up the scale. If you were planning to order six cases of an item, for example, and you found that a lower price was available for ten cases and a still lower price for twenty cases, you should give some consideration to the larger quantities provided you have the space, the need, and the budget.

This is the second section of Mr. Godlesky's lecture to the housekeeping extension course on the fundamentals of purchasing; it deals with quantity factors that affect buying. The third section, on price factors and sources of supply, will appear in June.

Several other common questions in relation to quantity purchases include: How much capital should be tied up in inventory? How large an inventory of various items should be maintained? For how long a period should we purchase?

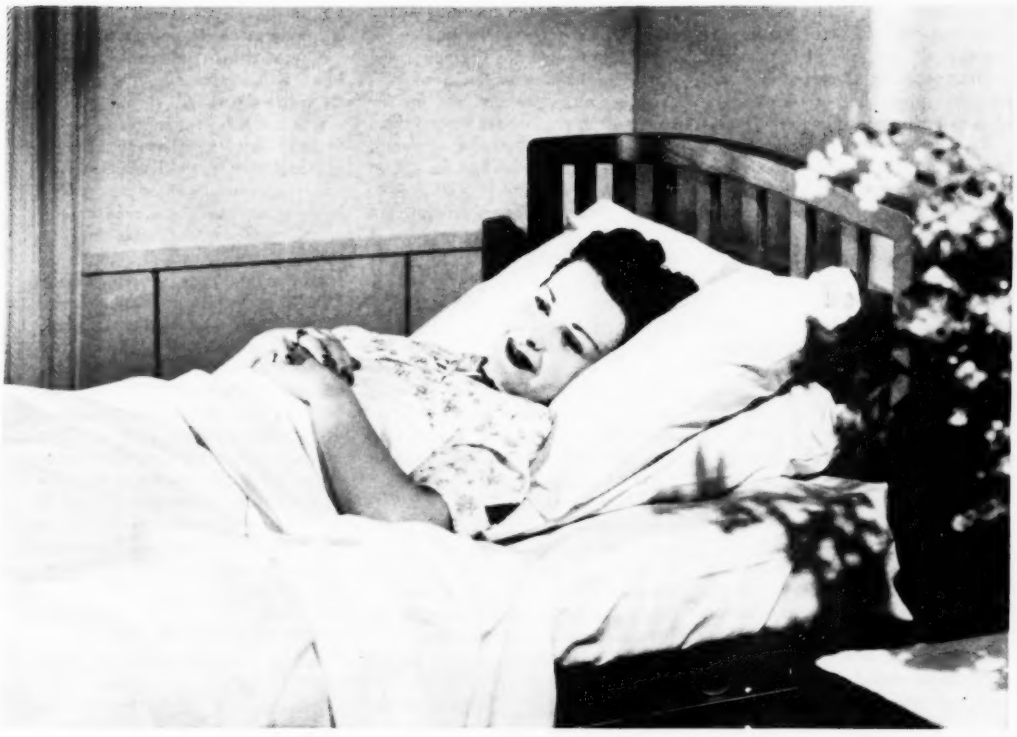
No one could give the exact answers to those questions even if he knew something about the institution's financial status, storage facilities, and the rate of consumption. However, one could point out some of the influencing factors in the answering of those questions.

Regardless of the plan on which you operate your purchasing and your inventory—whether on a strict maximum and minimum basis, that is, reordering when your stock has reached a designated minimum quantity to bring it up to a designated maximum quantity, or whether you order on a periodical basis, such as quarterly, semiannually or annually—you should give consideration to, and take advantage of, some of the factors that enter into decisions as to the most economical quantities to buy. Reference has already been made to quantity discounts as a factor in determining economical purchase quantity. Among other primary cost factors which are usually present are the following.

MARKET AFFECTS COSTS

Price trends. The movement of market prices is a factor which will favor the purchase of large or small quantities depending upon whether the trend is upward or downward. In times of rising prices, unit costs can be reduced by forward buying, while in times of falling prices, unit costs can be reduced by more frequent purchases of small quantities. In short, the buyer's judgment regarding future prices will have a direct effect on his decision regarding what quantities to buy at particular times. When prices are going up, try to buy at the low spots. When prices are falling, buy from hand to mouth—just enough to maintain an adequate inventory for continuous operation.

Impending shortages. Quite often information is made available to the effect that the supply of certain items is to be curtailed for a definite or indefinite period. If, in the judgment



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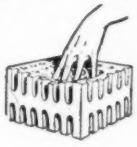
Write Hewitt Restfoam Division, Buffalo 5, New York, for complete details about all Restfoam hospital specialties—including operating table pads, ring cushions and fracture padding in addition to Mattresses and Pillows.



All natural latex foam! The Restfoam Hospital Mattress is self-ventilated . . . cooler in summer! No springs! No tufts! No padding! No dust-making materials to bother people with allergies!

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of the buyer, the information is reliable and well founded, a sufficient quantity of those materials that will be short might be purchased to ensure adequate supply during the shortage or curtailment period.

Rate of consumption. Since changes often occur in the rate of consumption of some commodities for various reasons—such as a change in technic or process which might reduce or increase the consumption of an item —it is important that a fairly accurate forecast of rate of consumption be made before a judgment is formed regarding the economical purchase quantity.

Freight differential. In some cases, vendors, particularly out-of-town vendors, prepay the freight on shipments involving several cases of an item but not on a single case. That is a point to consider in relation to quantity determination.

Obsolescence. Changes are continually taking place in all phases of business activity, and as a result the danger of obsolescence is always present in some degree. Obsolescence may arise from the development of new products or methods, the discovery of new materials, style changes, and so forth. We all are familiar with some of the changes brought about by the introduction of plastics and nylon in practically every field of manufacture; and I have already mentioned obsolescence caused by style change in the case of the uniforms and the "New Look." It is clear that the losses from obsolescence will increase with the length of time goods are kept in stock before being used, and these losses will constitute one of the disadvantages connected with purchasing in large quantities.

STANDARD ITEMS BEST

This might be a good place to re-emphasize the advantages of buying standard items rather than style, novelty or experimental items inasmuch as standard items are less likely to be discontinued from a manufacturer's line. In buying standard items, you can be reasonably confident that not only will the quality be uniform but that there is less hazard of the items becoming obsolete owing to nonacceptance by a using department.

Deterioration. Most materials which are held in stock are subject to a certain amount of deterioration. This factor will vary in importance depending upon the characteristics and particularly upon the durability of the product. For a perishable product, it is likely to be one of the primary elements in the determination of purchase quantities. In any case, the degree of deterioration will depend upon the time a product is kept in storage which in turn is related to the size of the purchase quantity.

This problem of deterioration might be given consideration in buying woolen blankets which are subject to the attack of moths when left in storage for a long time without proper mothproofing attention.

Needless to say, the foregoing factors are not in themselves sufficient criteria for determining the optimum purchase quantity; however, they are worthy of consideration if and when they are applicable to one's quantity purchasing problem.

It is apparent, too, that all of the foregoing cost factors will vary in importance in their relation to one another, and in their effect on the economical purchase quantity, depending upon the hotel or hospital, and upon the product. For example, in a resort hotel with only a three or four months' season, the obsolescence and deterioration factors might demand more attention than they would in a hotel or hospital operated the year around where there are longer continuous periods in which to use up a product. In an institution which has ample storage space and capital, the trend of market prices and the rate of consumption might be of more importance than they would in the institution in which both capital and space are limited or restricted.

The problem of determining the optimum purchase quantity, then, is not one that can be solved in terms of generalities, but one that must be solved for a particular product in relation to the particular set of circumstances connected with the hotel or hospital for which the purchase is being made.

In the purchase of a specific product, the buyer's first task is to select those factors which are pertinent to the situation at hand. The next step requires the exercise of judgment on the part of the buyer to determine the extent to which each of those factors will affect the decision as to the economical purchase quantity.

Having exercised his judgment with respect to each of the cost factors in the situation, however, the buyer has still the problem of balancing and correlating his judgments on each of those factors to arrive at a single figure for the economical purchase quantity which will represent his judgment of the entire situation.

It is not always as simple or as difficult as just that, however, because in many cases in which quantities are involved, especially those representing large expenditures, there is another person who usually enters into the buying picture, either to question our judgment or to offer advice and assistance. That person is "Management," that is to say, the director or manager of the institution.

Inasmuch as the buying policy of an organization is essentially a responsibility of management, it is a matter of practical common sense for management to interest itself when a proposed purchase involves a large expenditure and a decision has to be made as to whether to invest its resources in inventory or equipment, or to use the funds for some other business purpose.

CHECK WITH MANAGEMENT

When a situation arises in respect to a large quantity purchase which the buyer feels would be especially advantageous to his institution, he should bring a recommendation to the manager or director to whom he is responsible with the reasons he considers the extraordinary expenditure advisable. If management concurs in this judgment, the purchase is authorized and made through the regular channels. In that way, the buyer has not evaded his responsibility of trying to obtain the most for his company's dollar, nor has he presumed authority beyond the usual scope of his office. And the ultimate decision recognizes both the purchasing and the management policy.

Other guiding influences in quantity purchases found in some institutions are monetary limits placed on the size of orders that can be placed without special authorization, and budgets set up to keep expenses within specified limits.

Before leaving the discussion of quantity purchases, I think it is important to call your attention to a phase of buying that leads to cumulative expenses of which we should be conscious and which we should try to avoid and discourage, *i.e.* the tendency toward small order buying.

If you were to make a survey of your own buying habits, it might sur-

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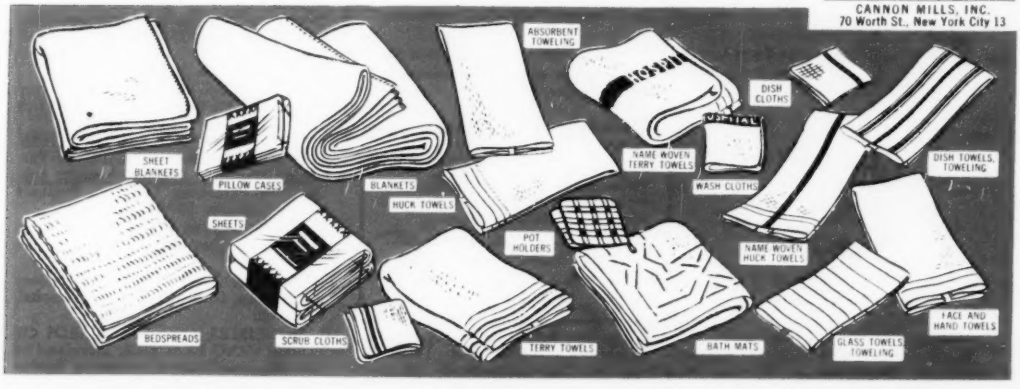

prise you to find how many hundreds of orders you were writing in one year under $5 or $10. These small orders all cost money in your own department, in the receiving, stores and accounting departments; and not only that, but they are costing your suppliers additional expenses which, in the final analysis, you must pay.

Now, since a justifiable criticism should always be accompanied by suggestions, let me offer the following in the matter of small order buying:

1. Plan to buy your stock items for longer periods—for three months, six months or for one year, instead of for one week or one month. The most recent monthly survey of the buying policy of the New England Purchasing Agents shows that the majority of the purchasing agents are buying on a three months' basis at the present time.

2. Accumulate special requisitions for the weekly or bi-weekly ordering, setting aside a particular day for this purpose. Don't order bits of the same materials every day or every few days.

3. If orders are not sufficiently large, investigate possibilities of requirements of stock items needed in the immediate future of similar lines. If you are in the market for one bolt of material, for example, check your stock to see if you will soon be needing other materials in the same category.

Quantity purchases not only tend to reduce selling and handling expenses for the seller, but often beget better prices for the buyer.

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PRINCIPLES AND STANDARDS OF PURCHASING PRACTICE. Advocated by National Association of Purchasing Agents.

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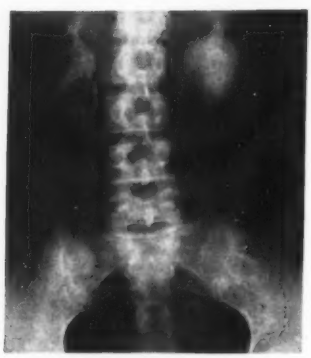

Intravenous urogram showing left hydronephrosis.

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That's not all. New fluoroscopic features give you more detail . . . easier handling of the fluoroscopic carriage . . . and locks that you can manipulate with gloved hands. Too, there is the new G-E spot-film device producing radiographs viewed *without* inversion. Each exposure automatically aligns with center of primary x-ray beam. Photo-timing is optional.

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NEWS DIGEST

Patient Steals Show at New England Meeting . . . Mental Hospitals Fall Below Standards, Psychiatrists Say . . . Dr. Crawford Heads Ohio Association . . . Name Psychiatric Aide of the Year . . . International Hospital Congress Opens

Patient's Plea for Kindness Steals Show at New England Hospital Assembly in Boston

BOSTON.—A voice from the floor stole the show at the 26th annual meeting of the New England Hospital Assembly. It came from an unassuming, modestly attired little woman, identified only as a patient from Providence, R.I., who, apparently unrehearsed, enacted feelingly the rôle of a patient in the panel discussion "The Patient Speaks."

"I am old, unattractive to look at and without means," she announced. "All I ask of any hospital is that I be treated with kindness." Immediately she won her audience. Another round of applause followed her suggestion that it might be well if admitting clerks and others were to remember that some of the unprepossessing old people who enter their doors may be thinking about making legacies.

Opinion cards or other means of checking patients' reactions to services rendered comprise an important part of the hospital program, Dr. T. Stewart Hamilton, director, Newton-Wellesley Hospital, Newton Lower Falls, Mass., and Alfred H. Marshall, assistant director, Grace-New Haven Community Hospital, New Haven, Conn., agreed. They are a help to the administrator as well as to department heads and tend to keep personnel on its toes.

That the nurses' attitude is indicative of the hospital's attitude was emphasized by Margaret M. Shrader, superintendent of nurses, New England Deaconess Hospital, Boston. Nurses, in other words, must be imbued with the principles of the hospital. Doctors, too, can help, by interpreting hospital service to the patients, contributed Dr. Leland S. McKittrick, visiting surgeon, Massachusetts General Hospital, Boston. They can prepare the patient for his hospital experience by explaining visiting hours, why it is essential that he be admitted at certain hours, and why he may not need special nurses. It lies within the power of the doctor to serve as an educator on what is good medical care.

New England officers, l. to r.: Dr. Gerald F. Houser, treasurer; Paul J. Spencer, vice president; Lester E. Richwagen, president; Dr. Albert E. Engelbach, retiring president, newly elected trustee of the association.

The fireworks that were anticipated in the appearance of Oscar F. Ewing, Federal Security Administrator, Washington, D.C., failed to materialize. Mr. Ewing, it seems, was not sufficiently convalescent from his own recent hospital experience to put in an appearance. Instead, the place of voluntary hospitals in the proposed federal program was outlined in persuasive tones by Mary Switzer of the same office, who needs no introduction to New England hospital audiences.

There is nothing for our voluntary institutions to worry about in the proposed national health insurance program, Miss Switzer would have us believe. The administration of such a program need not imply interference. Whatever form the program will take, the voluntary hospital has a vital and irreplaceable rôle to play. To which assertions such national hospital figures as Joseph H. Norby, president, American Hospital Association, and James A. Hamilton, director, School of Public Health, University of Minnesota, replied with gusto, as follows:

Said Mr. Norby: "The voluntary hospital will go out of the picture if the national compulsory health plan goes

(*Continued on Page 156.*)

American Hospital Leaders to Attend International Hospital Congress in June

AMSTERDAM, NETHERLANDS.—American hospital leaders taking part in the first postwar International Hospital Congress here May 30 to June 4 include Dr. Donald C. Smelzer, chairman of the international relations committee of the A.H.A.; George Bugbee, executive secretary of the A.H.A., and Dr. Vane Hoge, director of the division of hospital facilities, U.S. Public Health Service.

Two days of the congress will be held in this city and then the delegates move out by bus through picturesque North Holland and the reclaimed land of the Zuyderzee to Groningen for another three days' sessions.

A number of trips by boat along the canals and in the harbors have been arranged, as well as visits to hospitals and sanatoriums.

Among the papers scheduled in the preliminary program are one on the training of hospital administrators by Mr. Bugbee, and another on modern tendencies in hospital design, construction and equipment by Hugo van Kuyck, technical counselor of the public assistance board, Antwerp, Belgium, and a member of the Dutch Commission on Hospital Planning.

NEWS...

"No Class A Mental Hospitals," Speakers Tell Delegates to Psychiatric Institute

PHILADELPHIA.—There are no Class A mental hospitals in the United States nor will there be for 10 years, the administrators of psychiatric institutions from 40 states and six Canadian provinces were told at a five-day institute held here in mid-April under the sponsorship of the American Psychiatric Association.

This was the first conference of its kind to be held in this country. It convened at Pennsylvania Hospital where the first meeting of the association was held more than 100 years ago.

"The inability of mental hospitals to comply with standards set by the association is due not only to lack of funds but also to the scarcity of available professional personnel," Dr. Mesrop A. Tarumianz, chairman of the standards committee, told those present.

"It is also obvious," he continued, "that our mental hospitals, particularly the public hospitals, have been neglected for generations because of lack of understanding on the part of the people and the lethargy of our various national medical associations and particularly psychiatrists."

There are about 490 public and private mental hospitals in this country, Dr. Tarumianz declared, and to comply with the association's standards these hospitals would have to employ 9000 psychiatrists, 3000 neurologists, 3000 clinical psychologists, 40,000 graduate nurses, 92,000 trained attendants, 4800 physical therapists and hydrotherapists, 12,000 occupational therapists, 8000 recreational therapists, 3000 psychiatric social workers, 3400 dietitians, and 1500 laboratory technicians.

Added to these would be needed trained personnel for mental hygiene clinics, schools, colleges, medical schools, and private practice.

Dr. George S. Stevenson, president-elect of the American Psychiatric Association, charged that our mental hospitals are deteriorating in that they are failing to give their patients what modern medicine has to offer.

At the same time, Dr. Stevenson asserted, unless the basic attitude of the public is changed from one of blaming governors and hospital officials for bad conditions in mental hospitals to one of "facing its own fears," the hospitals will not be able to do the job they should.

Dr. William C. Menninger, president of the association, told the delegates that there is not enough money appropriated by the legislatures of the various states to do much more than keep the patients living, without means to cure them.

"You cannot get adequate personnel for the mentally ill without money. You can't do research without money. To get these funds the pressure must come first

(*Continued on Page 160.*)

Three Catholic Groups Offer New Health Plan

WASHINGTON, D.C.—A health plan that would let states set up their own voluntary health insurance programs has been proposed by three Catholic organizations: the bureau of health and hospitals of the National Catholic Welfare Conference, the National Conference of Catholic Charities, and the Catholic Hospital Association. The plan was offered as an alternative to President Truman's proposal for compulsory national health insurance.

Bishop Karl J. Alter of Toledo stated that there is no controversy over the need for a health prepayment plan but plenty of argument over whether it should be voluntary or compulsory.

In a message to Congress on April 22, President Truman reiterated the need for compulsory health insurance and added six new features to his program. In addition to the insurance system which would require a 3 per cent pay roll tax on income up to $4800 per year, shared equally by employe and employer, the program calls for:

1. **Aid to medical education.**
2. **Subsidies to encourage physicians to practice in rural areas.**
3. **Increased grants for hospital construction.**
4. **Expansion of public health services.**
5. **Extension of maternal and child health programs.**
6. **Grants to stimulate medical research.**

The plan offered by the Catholic organizations would set up a division of health in the Federal Security Administration, directed by a federal health council composed of three doctors, three hospital administrators, and three public members. Similar state and local councils were proposed. The government would increase its grants for hospital construction and pay subsidies to help operate hospitals in "areas of need." Federal funds would be provided to help medical schools, establish scholarships for medical students and offer cash inducements to physicians to go into poor areas.

Federal funds would be given the states to provide medical care for those in the lowest income brackets or "without any income." The government would also build community health centers in rural areas of special need and encourage enrollment in voluntary health insurance plans.

Blue Cross Payments Reach $270,928,123, Colman Reports at Conference

HOLLYWOOD-BY-THE-SEA, FLA.—At the opening session of the annual conference of Blue Cross plans here on April 19, J. Douglas Colman, chairman, Blue Cross Commission, and executive director, Maryland Hospital Service, Baltimore, reported that a total of $270,928,123 was paid to hospitals by nonprofit Blue Cross plans for the care of Blue Cross members in 1948. Payments for members' care in 1948 were $59,535,238 greater than in 1947, Mr. Colman said.

Total income for all Blue Cross plans in 1948 in the United States and Canada was $317,473,030, and 85.34 per cent of that amount went directly to hospitals for service to members. An additional $15,687,702, or 4.94 per cent, was allocated to reserves for future hospitalization. Combined operating expenses of all plans were $30,857,205, or 9.72 per cent of income, the lowest ratio of operating expense to total income recorded in Blue Cross history, Mr. Colman stated. As compared with the operating expense of former years, the 1948 figure of 9.72 per cent is 1.42 per cent lower than in 1947 and 3.29 per cent lower than in 1946.

Payment of the $270,928,123 by the 90 Blue Cross plans covered hospital care rendered on a service basis for more than 3,500,000 Blue Cross members as bed patients and represented more than 26,000,000 hospital days' care, Mr. Colman stated.

Enrollment in Blue Cross plans in the United States, Puerto Rico and Canada numbers more than 33,000,000 persons.

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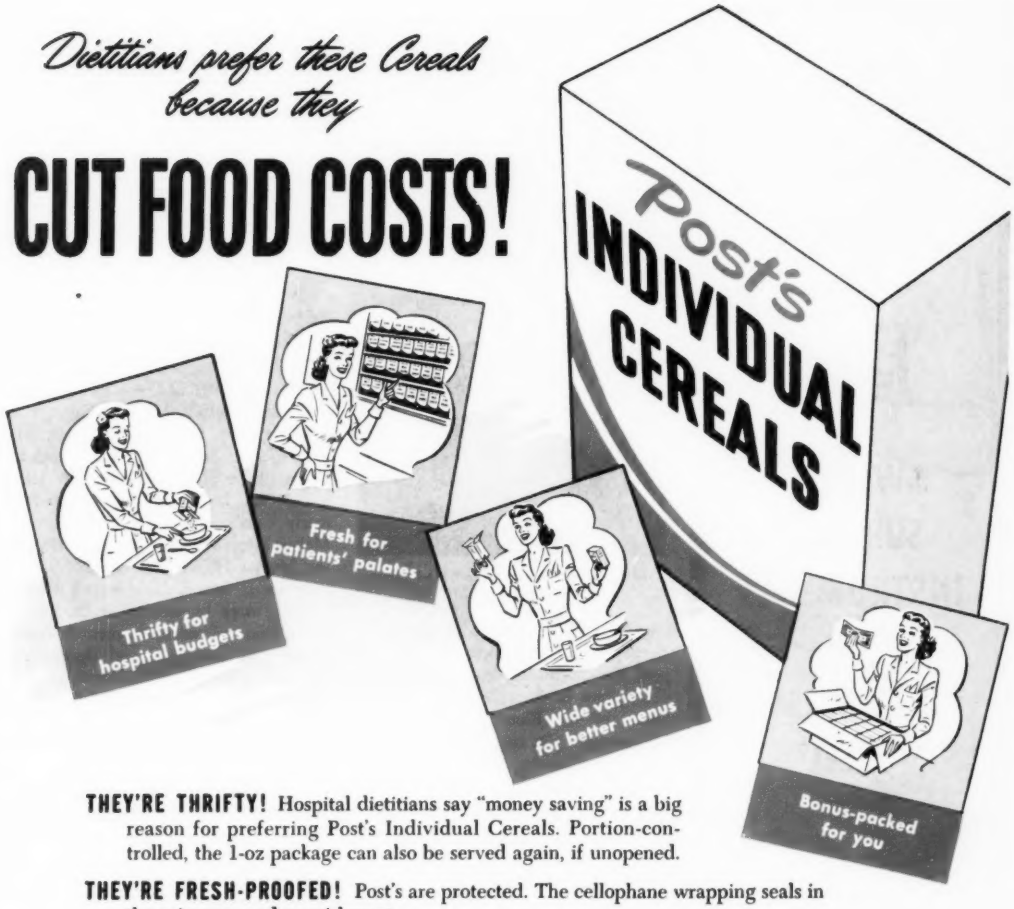
CUT FOOD COSTS!



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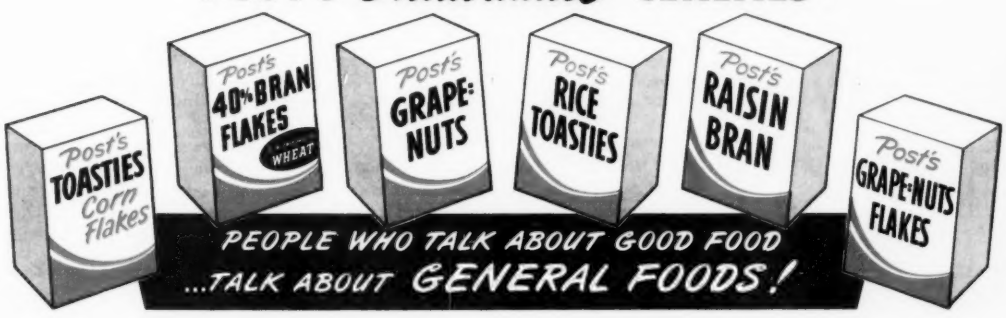
POST'S *Individual* CEREALS



PEOPLE WHO TALK ABOUT GOOD FOOD ...TALK ABOUT GENERAL FOODS!

NEWS...

Dr. Russell B. Crawford Named President-Elect of Ohio Hospital Group

COLUMBUS, OHIO.—At the close of a four-day meeting here, close to 1000 members of the Ohio Hospital Association named Dr. Russell B. Crawford, superintendent of Lakewood Hospital, Lakewood, president-elect.

Robert M. Porter, administrator of Children's Hospital, Columbus, handed

Robert Porter hands gavel to Miss Robinson.

over the gavel to Nell Robinson, superintendent of City Hospital, East Liverpool, the incoming president.

Dr. Paul R. Hawley, chief executive officer of the Blue Cross-Blue Shield Commission, was one of the top speakers. "Compulsory government health insurance is identified with all the bankrupt nations in Europe," he declared, "and they are surviving today only because the United States is a free enterprise nation."

Much the same note was sounded by Dr. Alfred P. Haake, economist-consultant to the General Motors Corporation. If hospitals and doctors are to be socialized by the federal government, he warned, "other professions and business in general would be almost sure to follow. Ultimately, all standards of living would be lowered."

Robert F. Kleene, manager of Toledo's Central Hospital Bureau, told the group that "chiselers" are in the minority among hospital patients.

"We should not add the economic straw to the camel's back by enforcing the payment of a hospital bill on a family barely able to stay off relief rolls," he declared.

However, economics was only one of the major issues of the convention. Each afternoon the program featured talks on better service to the hospital by special groups: registered nurses, practical nurses, record librarians, medical technologists, pharmacists, occupational therapists, nurse anesthetists, dietitians, housekeepers, purchasing agents, and maintenance engineers.

Other officers named were: first vice president, Frank C. Sutton, Miami Valley Hospital, Dayton; second vice president, Sister Mary Aquin, St. Rita's Hospital, Lima. Rt. Rev. Msgr. M. F. Griffin was reelected treasurer.

Robert Felix to Head National Institute of Mental Health

WASHINGTON, D.C.—A National Institute of Mental Health, which was authorized by the 79th Congress, has been created in the National Institutes of Health, research branch of the Service. It will continue the program formerly carried out by the Division of Mental Hygiene in the administration of the Mental Health Act of 1946. This program is specifically directed toward gaining more knowledge of the cause, prevention and control of mental illness, training of personnel and developing community mental health facilities.

Dr. Robert H. Felix, chief of the Division of Mental Hygiene since 1944, has been appointed director of the National Institute of Mental Health and the Division of Mental Hygiene has been abolished. Dr. Felix will serve under the general supervision of Dr. R. E. Dyer, director of the National Institutes of Health.

In announcing the establishment of the National Institute of Mental Health, Dr. Leonard A. Scheele, the surgeon general, pointed out that mental illness accounts for the hospitalization of more than 600,000 patients, and partial incapacitation of millions more persons. It likewise is a basic cause of many of the great social problems—delinquency, crime, divorce, alcoholism—which today afflict society.

"Experience has proved," he said, "that the solution to human illness requires the cooperative skills of many scientific disciplines. By becoming part of the National Institutes of Health, the mental health program will be able to take full advantage of the extensive investigations being made into other diseases as well as of the programs of basic research in the various laboratories and organizations of the National Institutes of Health."

The Advisory Mental Health Council, which was created by the National

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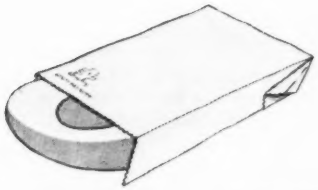

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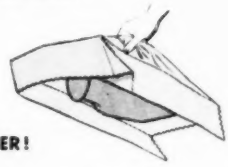

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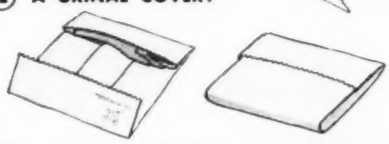

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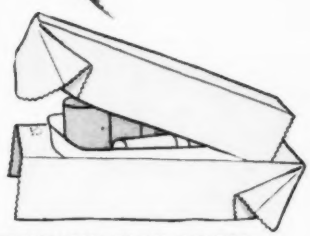

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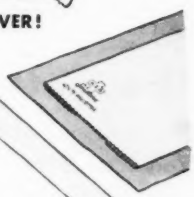

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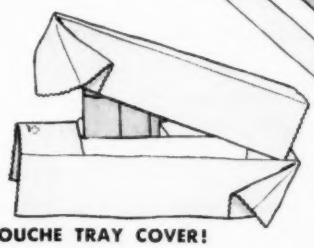

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NEWS...

Mental Health Act, will assist in the formulation of policies for the new institute. The council consists of six outstanding authorities in the mental health field.

Temporarily, headquarters of the National Institute of Mental Health will be located in the Federal Security Building, Washington, D.C. Transfer will be made to the National Institutes of Health at Bethesda as soon as new buildings, now under construction, are completed.

Associated Hospital Service Report Reveals Peak Enrollment of 3,626,321

NEW YORK.—Associated Hospital Service, New York's Blue Cross plan, has reached a new peak with a total enrollment of 3,626,321, Louis H. Pink, president, announced in the annual report issued April 14. Enrollment for 1948 was 420,143.

A total of $32,720,142.80 was paid to hospitals for the care of 356,904 members. With the exception of maternity cases, 92 per cent of those who received care in semiprivate accommodations had their hospital bills paid in full.

The effect of rising hospital costs on the financial structure of the plan is revealed in figures which show that average daily payments to member hospitals for the care of nonmaternity patients in semiprivate accommodations rose from $6 in 1935 to $15.40 in 1948. The greatest increase, from $10 to $15.40, took place in the 16 month period between May 1947 and September 1948.

Mr. Pink, in his annual message, pointed out that high hospital costs which reached a peak during 1948 made it necessary to increase payments to hospitals and to provide for an increase in subscription charges. While A.H.S. payments to hospitals have been increased approximately 150 per cent since the organization was founded, he said, the only previous increase in subscription charges to members, put into effect in May 1947, amounted to an average of 33 per cent for all types of contracts.

According to Mr. Pink the new payments to hospitals are in accordance with a formula based on the charges and costs of each hospital. The formula is fair to the public and hospitals, he declared, and at the same time adaptable to changing conditions without the need for constant negotiation. He suggested that benefits may be broadened or subscription charges reduced if such action is justified by experience under the new rates.

Chicago to Build Cancer Research Hospital

CHICAGO.—A $3,500,000 hospital to be known as the Argonne Cancer Research Hospital is to be built here. The six-story, 50 bed structure will be operated by the University of Chicago staff and will be integrated with the work at Billings Hospital and the Nathan Goldblatt Memorial Hospital for Neoplastic Diseases, now under construction. Most of the radioactive substances the hospital will use will be obtained from the Argonne Laboratory, 25 miles southwest of the hospital. The new structure, which will be built on the University of Chicago campus, will be ready for use by 1951.

NEWS...

Roland Brand Named Psychiatric Aide of the Year by Mental Health Foundation

PHILADELPHIA.—Roland J. Brand, an attendant at the Milwaukee County Asylum, Milwaukee, has been named recipient of the "Psychiatric Aide of the Year Award" for 1948, according to an announcement April 21 by Richard Hunter, executive secretary of the National Mental Health Foundation, on behalf of the foundation and the Catherwood-Kirkbride Fund for Research in Psychiatry, joint sponsors of the award.

Every mental hospital in the country, both public and private, was given an opportunity to nominate the attendant or psychiatric aide on its staff who had turned in the most meritorious performance during 1948. In all, more than 15,000 eligible candidates were considered by hospitals throughout the country before the final selections were made by a board of judges, prominent in the field of mental health.

For his achievement in removing restraints from 32 male patients on the most disturbed ward at the Milwaukee institution, overnight, and in completely banishing the continued practice of restraints on his ward and thereby setting an example for the rest of his fellow employes, Mr. Brand will receive a cash prize of $500 and a citation.

Roland Brand, at left, named "psychiatric aide of year" by mental health foundation.

Commenting on the selection of Mr. Brand as the nation's Number 1 psychiatric aide, Mr. Hunter stated:

"Brand's achievement is a practical demonstration that sympathy, understanding, intelligence and proper training are far more effective tools in the care of even the most disturbed mental patients than the brutal mechanical devices."

Five other candidates who reached the finals in the competition are being cited for honorable mention. They will receive $50 awards and appropriate citations for their exemplary performances in the care of the mentally ill. They are: Mrs. Elizabeth Guy, St. Elizabeths Hospital, Washington, D.C.; Mrs. Zella Bauer, Chicago State Hospital, Chicago; Joe Collins Hisle Jr., Veterans Administration Hospital, Lexington, Ky.; John Robert Hull, Ypsilanti State Hospital, Ypsilanti, Mich., and Thomas R. Cobb Jr., Veterans Administration Hospital, Roanoke, Va.

Mr. Brand, who is 57, joined the attendant staff at the Milwaukee County Institution in January 1935. In seconding his nomination by his fellow employes, Dr. Ralph M. Fellows, medical director of the institution, stated:

"His greatest accomplishment, that of taking 32 patients out of restraint, some of whom had been in restraint for years, followed a visit to the Manteno State Hospital, Manteno, Ill., where the use of restraints had been abandoned by state law many years ago. While observing practices there, he wrote back to the hospital here, stating he saw no reason

NEWS...

why restraint could not be removed from the patients here.

"At the time of his return from Manteno there were 32 patients on his ward who were in full mechanical restraint. Every one of these patients was released on the first day he was back on duty. The doctor in charge issued a standing order for sedatives if they should be needed, but so far that order has never been filled. This transition was made possible because of Brand's overwhelming concern for his patients as fellow human beings."

"The Psychiatric Aide of the Year Award" was established in 1947 by the foundation as part of its campaign to encourage the adoption of higher standards of care in mental hospitals, and this year has been made in cooperation with the Catherwood-Kirkbride Fund for Research in Psychiatry which is directed by Cummins Catherwood and Morton Jenks of Philadelphia.

The board of judges for the award included: Dr. Robert H. Felix, director, National Institute of Mental Health, Public Health Service; Harriet J. Smith, *Des Moines Register and Tribune;* Mary Jane Ward, author of "The Snake Pit"; George Ault, executive director, Washington Society for Mental Hygiene; Robert M. Cunningham Jr., managing editor, The MODERN HOSPITAL; Lela S. Anderson, R.N., nursing consultant of the American Psychiatric Association, and Dr. Robert L. Sutherland, director, Hogg Foundation for Mental Hygiene.

Health Center for Arkansas

CROSSETT, ARK.—Public bids have been received for the construction of the Crossett Health Center here which was designed by William Lescaze, New York City architect, for the Crossett Health Foundation of Arkansas. The building is to be completely air conditioned, to contain 52 beds and an extensive outpatient department which will serve not only the town of Crossett but the large rural areas surrounding it.

The bid accepted represents a cost of $15 per square foot or $12,400 per bed.

Architect's drawing of the proposed 52 bed Crossett Health Center, Crossett, Ark.

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For many years, Westinghouse has been engineering and installing elevators in hospitals all over the country . . . and has developed this specialized type of elevator to its highest degree of refinement.

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NEWS...

Taft Health Bill Provides Five-Year Program of National Aid to States

WASHINGTON, D.C.—Senator Robert A. Taft and two other Republicans on April 14 introduced into the Senate an omnibus health bill which provides for a five-year program of national aid to states instead of compulsory insurance.

Senators H. Alexander Smith of New Jersey and Forrest C. Donnell of Missouri are co-sponsors of the bill, which is their answer to President Truman's proposal.

Grants estimated at $1,955,000,000 over a five-year period, to be matched on a 50-50 basis by states, localities and hospitals, would be authorized to improve facilities and to provide services to persons unable to pay the full cost.

Mr. Taft and his colleagues estimated that the first-year cost of their bill would be $280,000,000, of which $150,000,000 would be used to develop programs for extending medical and hospital services to persons unable to pay the full cost. Dental services could also be provided at a state's option.

Other grants would be authorized as follows:

For school health services, $35,000,000 a year.

For hospital construction, $150,000,000, as compared with the grants of $75,000,000 annually under present law.

For development of local public health services, an unspecified amount estimated at about $25,000,000 annually by 1952.

For maintaining and increasing enrollment in medical schools, $500 per school annually for each medical student up to its average past enrollment and $750 for each student above that average.

The bill would also create a national health agency in the executive branch of the government. It makes no provision, however, for a single health and welfare cabinet department. The sponsors said it recognized that the primary responsibility for health, welfare, education and housing rested with the states.

But when the states fail to meet any basic health or welfare problem, "it is the right of Congress to relieve the deficiencies," they asserted.

Sen. Wayne L. Morse, Republican, of Oregon, one of the sponsors of a voluntary health insurance bill introduced by Senator Lister Hill, predicted that there

would be "no serious problem" in working out an agreement with Senator Hill and Senators Taft, Smith and Donnell.

Senator James E. Murray, Democrat, of Montana, the chief sponsor of the Administration's compulsory health insurance program, attacked the new health bill as "the same charity medical care proposal which was indignantly rejected by every farm and labor organization" that testified before the Senate's labor and public welfare committee. He said that the Taft-Smith-Donnell proposal would "lead directly into the Russian system of state medicine."

The Taft-Smith-Donnell bill contains provisions designed to encourage federal employes to enter voluntary nonprofit health insurance plans. It also would authorize appropriations to enable the surgeon general's office to help states "establish and maintain adequately staffed and equipped local public health units."

The three senators said they were not offering the bill as "the final word in national health legislation." They also cautioned that any health or welfare program must be kept "within the financial resources of the government" and emphasized that federal assistance should not overlap with activities "which can be supported by private individuals and groups."

New York Hospitals Will Comply With Terms of Nurse Practice Act

ALBANY, N.Y.—Having lost their fight for one more year's postponement of the state Nurse Practice Act, hospital administrators of the state are making every effort to comply with the provisions of the law.

The act legally divides the field of nursing into two areas: the registered professional nurse with her three years of training, and the licensed practical nurse with at least nine months of training.

With a few specific exceptions, any person who is not either a registered professional nurse or a licensed practical nurse is forbidden to nurse for hire under penalty of a year's imprisonment, a $500 fine, or both. Not only hospital procedure but home care of the sick are involved.

Hospital opposition to the law has centered around the compulsory licensing of practical nurses and the setting up of a legal definition of practical nursing. The hospitals have contended that the nurse shortage makes the use of auxiliary workers necessary and that these attendants are always adequately supervised.

The New York State Nurses' Association declares that it will take a little time and a little adjustment for hospitals to comply with the provisions but that operations could be maintained if hospitals would set up teams composed of a registered nurse, a practical nurse and auxiliary workers.

Louis Schenkweiler, president of the Hospital Association of Greater New York, who had suggested several weeks ago that compliance with the law would be impossible without jeopardizing patients' welfare, said yesterday that members hospitals are "of course, trying to comply" now.

Superintendents of nursing at individual hospitals were much more certain than their directors that with judicious reassignment of jobs, compliance could become nearly perfect in a short time.

Surgeons' Scrub-Up Sinks of Crane Duraclay, San Gabriel Valley Hospital

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SAN GABRIEL VALLEY HOSPITAL

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SAN GABRIEL VALLEY HOSPITAL ASSOCIATION, INC.

Duraclay Pattern Bath, San Gabriel Valley Hospital

Duraclay Wash-Up Sinks, San Gabriel Valley Hospital

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* *Duraclay exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendations R-106-41 of The National Bureau of Standards.*

San Gabriel Valley Hospital is an outstanding example of the modern small hospital. Here, as for the largest institutions, Crane supplies not only a full line of Duraclay items, but also the washroom fixtures, plus a vast array of specialized plumbing equipment.

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NEWS...

Northwestern Establishes Radioisotope Unit for Research and Therapy

CHICAGO.—Northwestern University Medical School has established the newest radioisotope unit in the Middlewest which is designed to perform the triple function of instruction, research and therapy, it was announced last month by Dean J. Roscoe Miller.

Equipment for the unit's laboratories is being financed with a grant in excess of $27,000 from the Atomic Energy Commission through the Office of Naval Research.

In addition to providing instruments and other facilities for research involving the use of radioisotopes, the medical school unit will introduce several new courses into its undergraduate curriculum and has already formulated a proposed program of postgraduate medical instruction in the utilization of radioactive elements.

The third phase of the unit's operation, that of patient therapy, will involve the university's four affiliated hospitals, Wesley Memorial, Passavant Memorial, Evanston, and Children's Memorial, and one of its cooperating institutions, St. Luke's Hospital. Radioactive elements will also be made available to the medical school's Montgomery Ward clinics.

The Atomic Energy Commission will supply the needed radioactive materials from Oak Ridge, Tenn. They will be used for therapy in cancer and blood diseases, for diagnosis of thyroid diseases and, it is tentatively planned, for the localizing of brain tumors.

The unit consists of four rooms in the Montgomery Ward building in the university's medical center on the Chicago campus. The rooms are isolated in a wing from other departments of the school.

Name San Diego Officers

SAN DIEGO, CALIF.—The Hospital Council of San Diego County has elected the following officers for 1949: president, John H. Gorby, administrator, La Mesa Community Hospital, La Mesa, Calif.; vice president, W. W. Stadel, M.D., superintendent, San Diego County General Hospital; member of executive committee, G. W. Herrill, business manager, Guest House, Chula Vista, Calif. John H. Gorby will be the representative from this council to the Hospital Council of Southern California.

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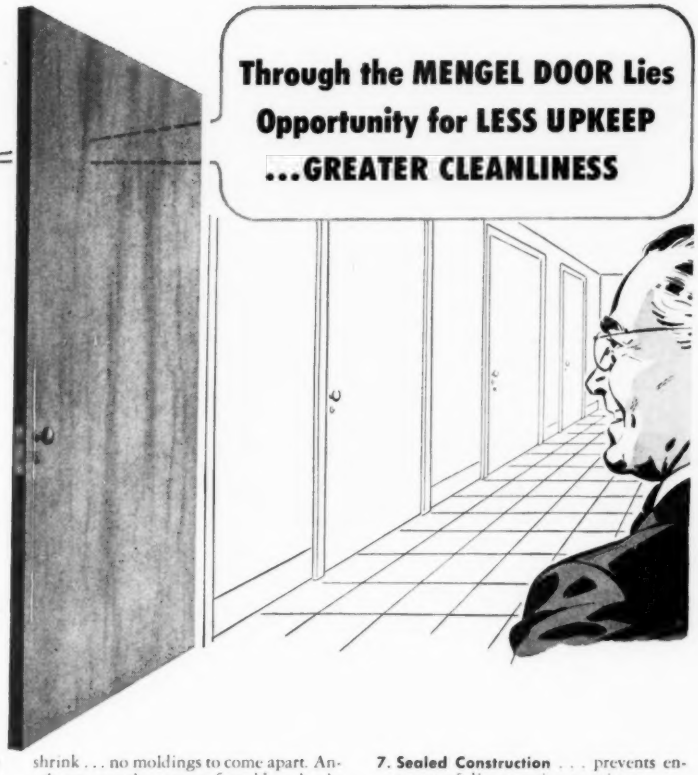

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IT'S MORE than just a beautiful door! It's an approved way of building durability and utility into any interior . . . regardless of decorative scheme.

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Only the Mengel Flush Door has the patented "Insulok" Grid Core which ends swelling and shrinking headaches (no more sticking doors!). And it makes Mengel Flush Doors much lighter than standard panel hardwood doors.

Built Like Fine Furniture! With hardwood framing . . . dovetailed, wedged construction . . . and 5-ply faces permanently bonded on.

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Mengel Flush Doors come faced with beautiful veneers of *Birch, Mahogany, Oak, Walnut, Gumwood* (and other hardwoods to order).

And they *stay* beautiful! Their smooth, unbroken surfaces are easy to clean . . . offer no place for dust to cling. No panels to shrink . . . no moldings to come apart. Another reason they are preferred by schools, hospitals and hotels.

Easy to Paint! The smooth Gumwood door is perfect for painting . . . never shows a grain raise.

Whether you're building or remodeling, remember, you get much more in a Mengel Door . . . the door with years of performance behind it. For full information consult your architect or builder . . . *and mail the coupon today!*

The Open-and-Shut Case for Mengel Doors

1. **An Engineered Door** . . . for greater strength . . . less trouble and upkeep.
2. **3-Ply Faces Bonded to Core** . . . with moisture-resistant glue.
3. **40% Lighter in Weight** . . . than standard panel hardwood doors.
4. **Warp-Resistant** . . . "cured" before leaving factory.
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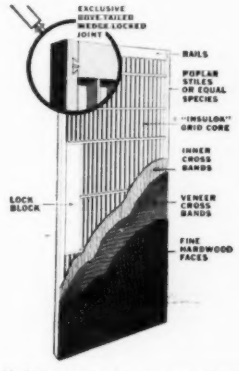
6. **Flame-Resistant Core** . . . made of nationally famous insulation board.
7. **Sealed Construction** . . . prevents entrance of dirt, vermin or moisture.
8. **Reversible Design** . . . permits door to be hung from either side without extra cost.



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NEWS...

Dr. Bayne-Jones Receives Medal From American College of Physicians

NEW YORK CITY.—Dr. Stanhope Bayne-Jones, president of the joint administration board of the New York Hospital-Cornell Medical Center, received the annual award, known as the James D. Bruce Memorial Medal, for outstanding achievement in preventive medicine at the 30th annual session of the American College of Physicians at the Waldorf March 28 to April 1.

Close to 4000 specialists in internal medicine attended the convention. Dr. Bayne-Jones received the medal chiefly for his work as an inspiring teacher at Johns Hopkins, Rochester and Yale universities, which had a part in shaping the careers of many young physicians.

In accepting the award, Dr. Bayne-Jones spoke chiefly of the rôle of hospitals in preventive medicine. He outlined the requirements for future expansion in this area: (1) development of diagnostic clinics for the examination of both sick and well; (2) enlargement of consultation services for patients and doctors of the community; (3) development of group practice both inside and outside the hospital; (4) extensions of hospital connections with private practitioners, particularly the general practitioner; (5) development of home care programs with a base in the hospital; (6) education and training in preventive medicine; (7) constant research.

"Hospitals should concentrate more on patients as individuals in a complex setting of personal, social, cultural and economic relationships and provide continuity of care," Dr. Bayne-Jones declared.

"At the same time, hospitals can bring to bear on an individual case a vast range of facilities within the institution and establish helpful cooperative relationships with physicians, organized medical groups, and federal, state, municipal and voluntary agencies.

"These relationships involve many difficult questions which come up for practical answers when new steps are taken to utilize the full potentialities of the hospital in carrying out preventive medicine."

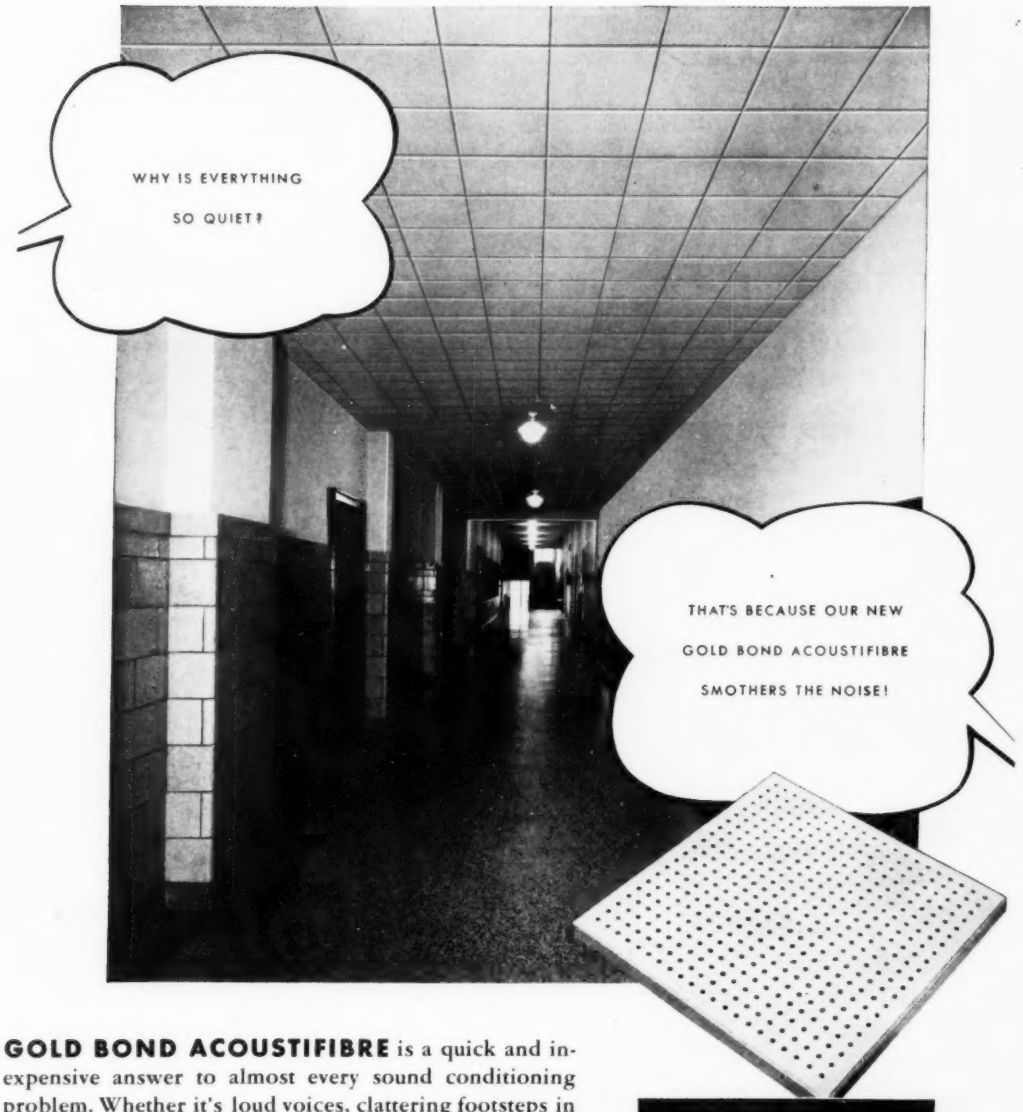
Dr. Walter W. Palmer, president of the American College of Physicians, told the delegates that short-term aid for research on specific projects may have a devastating effect on the continuation of clinical research and training.

"In the face of almost daily announcements of large sums given to medical research, these gifts have not brought much relief to medical schools," Dr. Palmer contended. "Very little of this money is given for the general purposes that might aid in the stabilization of the scientific departments. Short-term grants for short-term projects act to bring into the field young, short-term men and tend to increase quantity to the sacrifice of quality."

Principal speaker at the banquet was David E. Lilienthal, chairman of the Atomic Energy Commission.

Hospital Day Television Show

Maryland will observe National Hospital Day on May 12, with two television shows in addition to the usual spot radio broadcasts, news stories and window exhibits. The program is being sponsored by the Baltimore Hospital Conference.



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Two sizes of tiles are now available in three thicknesses to meet nearly all sound absorption requirements. And the new Acoustifibre is *drilled*—not punched—to give neat, clean perforations. The three-coat, factory-painted finish makes ceilings stay bright longer. They can be repainted, too, without loss of noise reducing efficiency.

Whatever kind of noise is bothering you, let us help you get rid of it! Just drop a card to Dept. H-95.

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A COMPLETE LINE FOR EVERY PURSE AND PURPOSE

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NEWS...

Doctor Who Opposed A.M.A. Fund Forced Off Program, Senator Morse Charges

WASHINGTON, D.C.—Dr. Myron E. Wegman, professor of pediatrics at Louisiana State University School of Medicine, was forced off a postgraduate course program at the University of Arkansas because he was one of the 136 signers of a protest against the A.M.A.'s "slush fund" to fight President Truman's health insurance program, according to charges made by Sen. Wayne Morse.

Dr. Edwards A. Park of Johns Hopkins University, who sponsored the round-robin letter protesting an A.M.A. assessment on each member — if the money was to be used for "propaganda and lobbying" rather than to develop a comprehensive health plan, told the *New York Times* that the barring of Dr. Wegman from lecturing at the University of Arkansas smacked of a "suppression of free speech."

Dr. Park further said: "I don't think the trustees of the A.M.A. will approve of the action of Dr. Ross." Dr. Ross is state health officer in Arkansas, and he wrote the following letter to Dr. Wegman, according to the *New York Times:*

"The Arkansas State Medical Society and the Pulaski County Medical Society have been advised through authoritative sources that you were one of the 136 signers of certain papers and documents severely criticizing the American Medical Association.

"Through this action on your part the Arkansas State Medical Society and the Pulaski County Medical Society request that you not appear on the postgraduate pediatrics course to be conducted on the above referred-to date. This department sincerely regrets that this most embarrassing situation has arisen and further regrets that it is necessary to cancel your appointment as special consultant for the Arkansas State Board of Health."

Vote A.M.A. Assessment

NEW YORK CITY.—At the largest regular monthly meeting in the history of the New York County Medical Society, 1700 members late in March overwhelmingly voted to pay the $25 assessment levied by the American Medical Association on all its members for a fight against compulsory health insurance.

Earthquake Shakes Hospital

Acme Photo

Interior of Western State Hospital, Fort Steilacoom, Wash., suffered severe damage in the earthquake that was felt throughout the Pacific Northwest on April 13. More than 1000 patients were forced to leave the main building for other quarters.

Structural Control of Curity Catgut to Assure

Absorption That Progresses Right on "Schedule"

As surgery is speeding to its conclusion, you can have the assurance that with the use of CURITY Catgut—every stage will be under control.

The effective performance of CURITY Catgut has been even further enhanced by TOTAL CHROMICIZATION plus *natural ply adhesion*. This process represents a notable advance in achieving increased absorption control.

These, and other advantages of CURITY Catgut are a result of *Balanced Quality*—the "built-in" quality and control that means an extra margin of safety and a smooth, uneventful recovery.

Curity Balanced Quality assures proper suture function

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NEWS...

Response to ACHA Program Is "Most Encouraging," Dean Conley Reports

CHICAGO.—Response to the American College of Hospital Administrators' campaign to raise funds for its expanded educational program has been "most encouraging," according to an announcement released by Dean Conley, secretary, at college headquarters here last month. Funds received include $1000 from the Alabama Hospital Association and a like amount from the Ontario Hospital Association.

The response from corporations approached for gifts to the fund indicates that "the educational program of the college has struck a responsive chord in those approached," the announcement said. "Similarly, the college membership has shown a serious interest in cooperating in the project as evidenced by the size of its contributions." Individual pledges as high as $1000 have been received, the report said.

"Particularly gratifying," said Dr. Wilmar M. Allen of Hartford, Conn., chairman of the campaign committee, "has been the response of individuals who have expressed an urgent desire to participate and who take pride in contributing to their college's money raising activity in the interest of better hospital administration."

Projects to be financed by the completed fund include scholarships for deserving hospital administration students, research in testing methods for selecting candidates, enlargement of universities' training programs and expansion of institutes and other in-service training facilities.

Nears Goal in Fund Drive

HAZLETON, PA.—More than $800,000 has been subscribed to the Hazleton St. Joseph Hospital building fund here in a communitywide campaign to raise funds to complete the construction of the new general hospital. Goal of the campaign is $973,000. The hospital, now partially completed, will be administered by the Bernardine Sisters and will contain such special services as a silicosis department for the treatment of anthracosilicosis (miners' asthma), a polio isolation department and a rehabilitation service for amputees. The campaign was carried on under the direction of Ketchum, Inc., of Pittsburgh.

NEWS...

Health Federation Members and A.M.A. to Seek Solution of Differences

CHICAGO.—The Cooperative Health Federation of America and a committee of the American Medical Association were to get together on April 29 in an effort to minimize the "dissension, disagreement and contention" between them and, if possible, to develop areas of agreement.

The C.H.F.A., consisting of 21 regular and 30 associate organizations operating an estimated 25 hospitals, "is taking steps to make sure that adequate encouragement of voluntary group action is contained in whatever national health legislation may be enacted by Congress."

Primary objectives sought by the consumer organizations under the leadership of the federation are:

1. Development of a greater degree of understanding between the A.M.A. and the voluntary health plans.
2. End of discrimination against doctors participating in voluntary prepayment plans having acceptable professional standards.
3. Support for the removal of legislative barriers to the formation of voluntary prepayment plans and for the enactment of enabling legislation for the organization of voluntary consumer-sponsored plans under proper standards such as have been enacted in Wisconsin with both lay and medical society support.

Representatives of the C.H.F.A. at the meeting were not limited to members of the organization but included such consumers of medical care as the Grange, the American Federation of Labor, the machinists' union, and the Congress of Industrial Organizations.

Committee Urges Program to Assist Doctors Trained in Foreign Medical Schools

CHICAGO.—A program to assist foreign trained doctors who seek to practice in the United States has been urged by the Committee on Foreign Medical Credentials, an unofficial group sponsored by the American Medical Association's Council on Medical Education and Hospitals. The recommendation was contained in a report of the committee which appeared in the *Journal of the American Medical Association* for April 16.

An editorial in the same issue commented that when reliable information about foreign medical schools is obtained it should be possible for accrediting agencies to prepare a list of foreign medical schools whose graduates may be considered to have received training comparable to that offered by medical schools in this country.

"It would then seem reasonable that the state boards and the National Board of Medical Examiners admit graduates of these schools to examination, provided they can demonstrate sufficient familiarity with recent scientific advances, with the practices and customs of American medicine, and with the English language.

"The Council on Medical Education and Hospitals probably will give major consideration to this suggestion at its next meeting. The report of the committee undoubtedly will prove to be an extremely useful instrument for promoting better understanding and better management of a problem that demands intelligent and enlightened solution."

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Quick, Thorough Disinfection

AT A COST THAT MAKES SENSE

"Another patient is coming right down from delivery. You have only a few minutes to prepare this room."

No wonder hospital personnel are getting gray hairs—what with the terrible pressure of crowded, rushed conditions. No sooner is a room vacated than it must be ready for occupancy again—straightened up, linen changed, all surfaces disinfected with "Lysol."

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DOES THE JOB RAPIDLY, THOROUGHLY, ECONOMICALLY.

▶ **Only 2.4¢** a gallon—that's all "Lysol" costs in 1% solution . . . the solution recommended for general disinfection.

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▶ **Strict laboratory control** assures that every batch of "LYSOL" is absolutely uniform in composition and action, completely soluble with neutral reaction, and free from impurities.

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NEWS...

Hamiltons Give $3500 to Establish Student Awards at University of Minnesota

MINNEAPOLIS.—Gifts totaling $3500 made to the University of Minnesota by James A. Hamilton, professor of hospital administration, and Mrs. Hamilton, will be used to establish two new awards for students in hospital administration.

Acceptance of the gifts was recently approved by the university's board of regents. The two student prizes, the James A. Hamilton Achievement Award and the Sabra M. Hamilton Award in Hospital Administration, will be presented from funds set up with the $3500.

Both awards will be made annually, each to a student in the second year graduate class. They will be presented in June, beginning this year, and public announcement of the winners will be made at the following Cap and Gown Day convocation.

The achievement award will go to the student who has completed with the highest standing all requirements for the degree of master of hospital administration and who shows the greatest promise of achievement. The prize will be something of intrinsic value, properly inscribed, such as an engraved desk set.

The Sabra M. Hamilton Award will be presented for the best formal report of the year on a research or management project. It will consist of two or more books of significant value to the library of a hospital administrator.

Plaques will be hung in the hospital administration area of the school of public health at the university and will be engraved each year with the names of the winners.

Health Committee Report Charges A.M.A. Monopoly

WASHINGTON, D.C.—A study presented to President Truman at the White House today by the Committee for the Nation's Health charges that monopoly practices of the American Medical Association's state and county societies are depriving American families of better and more comprehensive medical insurance plans at reasonable costs.

The report, entitled "Restrictions on Free Enterprise in Medicine," was prepared by the Committee on Research in Medical Economics, under the chairmanship of Michael M. Davis.

The 24 page document asserts that state and local medical societies use restrictive state legislation, boycotts and other professional pressures to block the growth of health insurance plans providing comprehensive medical services and sponsored by industries, unions, cooperatives, farmers and other consumer groups.

Campaign for $100,000

DEWITT, IOWA.—A campaign to raise $100,000 by public subscription to assure construction of a new hospital here was organized early in March. Clinton County voters recently rejected a proposal to authorize a $100,000 bond issue for the hospital. When the plan was first undertaken a fund of $100,000 was raised by public subscription, a site was donated and federal and other grants of $160,000 were pledged to become available when the project was formally approved. The new campaign will assure funds sufficient for a 35 bed institution which is the goal of the proponents.

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If fast, low-cost dishwashing is your aim, don't let hard water conditions or other problems hold you back. Switch to *specialized* Wyandotte Compounds.

If you wash dishes, glasses and silverware by machine, start using ***Wyandotte Keego****. This free-rinsing, non-corrosive product does a thorough washing job *in any water*. It also helps prevent scale formation in the machine.

If you wash by hand, get ***Wyandotte Neosuds****. Neosuds makes abundant suds, in hard as well as soft water, but contains no soap. It's easy on the hands and insures bright, sparkling dishes and glassware, free of film, streaks and water spots.

If you prefer a well-balanced *soap* product for heavy-duty washing, we suggest ***Wyandotte H.D.C.**** ***Wyandotte G.L.X.**** detarnishes silverware safely and quickly.

Wyandotte Steri-Chlor* is an all-purpose germicide for use after the washing operation. It makes a clear solution, immediately . . . destroys unseen bacteria . . . leaves no undesirable taste or odor. It also makes an excellent germicidal rinse for workers' hands.

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NEWS...

United Medical Service Membership Is 1,128,798

NEW YORK.—Total enrollment in United Medical Service here was brought to 1,128,798 by the addition of 399,338 persons during 1948, it was announced by Dr. Charles Gordon Heyd, president, in the annual report for 1948. Enrollment is now 20 times greater than it was when U.M.S. was founded in 1944 with 56,925 members from its parent organizations, Community Medical Care and Medical Expense Fund of New York. At the end of 1948 approximately 16,000 physicians, located in 17 New York State counties, participated in the program.

According to the report, U.M.S. paid 88,993 doctors' bills amounting to $4,170,730.52 in 1948 as against 49,022 bills amounting to $2,200,738 in 1947. Since the organization was founded, 164,204 bills amounting to $7,609,672.87 have been paid.

Of the 1,128,798 U.M.S. members, 811,058 are enrolled in the surgical plan which provides allowances toward physician's fees for surgical care in the hospital or doctor's office and for maternity care in the hospital. A total of 273,714 is enrolled in the surgical-medical plan which entitles members to the benefits of the surgical plan plus allowances for medical care in the hospital. The remaining 44,026 members are enrolled in the general medical plan which provides all the benefits of the other two plans plus allowances for medical care in the home or doctor's office. The general medical plan also makes certain allowances toward specialist's fees.

Pointing out that the rapid enrollment of U.M.S. has surpassed the record of Associated Hospital Service, its affiliate organization, in a comparable period of time, Dr. Heyd said: "Our remarkable growth provides us with a basis for appraisal. The day-to-day acceptance of this type of medical prepayment indicates that a social want is being supplied and that the services rendered represent the highest standards of medical care."

Albany Hospital Announces $3,500,000 Expansion Plan

ALBANY, N.Y.—A $3,500,000 expansion program of the Albany Hospital and medical college will start this summer. By 1951 the expansion should be completed. Among other facilities, it will include about 140 additional beds to relieve the bed shortage in such services as brain surgery, chest surgery and plastic surgery; a mental health clinic; a complete new outpatient department with ample laboratories and facilities; a complete new suite of emergency rooms with related facilities; additional operating rooms and operating room facilities, and additional nursery space for the newborn.

The new west building will provide the medical college with the following: an auditorium seating 150; three lecture rooms seating 80 and four seating 20; enlarged laboratory space permitting each laboratory to be used by 80 students rather than 50 as at present; several new laboratories; four conference rooms; enlarged library space making possible a library three times as big as the present one, and a diagnostic clinic.

Bids will probably be let for the new building in June or July and it is expected that the building will be completed by July 1951.

"...and stop at the cigar store for a dozen eggs!"

Perhaps it wouldn't seem so very surprising, nowadays, to find a cigar store selling groceries ... after all, the grocer often sells cigars, and many a druggist owes his success to the skill of his short-order cook!

But such topsy-turvy business is out of place in so serious a matter as the procurement of hospital laboratory equipment. Wouldn't it seem highly advisable to turn for laboratory equipment to men whose *business* is the designing, planning and manufacture of such products, rather than to the contractor furnishing the sashes, doors and similar millwork for your new facilities?

Certainly you want the best laboratory procurable for your money. You may be sure of it if you follow this procedure—

Ask your architect to keep your laboratory equipment specifications apart from the general building data. This makes it possible for specialists like ourselves to bid on these highly specialized units—cabinets, cases, sinks, fitted tables and work-tops, fume hoods and other components — without the penalty of having to add a middleman's compensation to our prices. You will be able to draw freely on a truly vast fund of technical experience.

You will get equipment better in dozens of important ways than your laboratory dollars can buy from the "general practitioner," and it will probably cost less.

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NEWS...

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, Municipal Auditorium, Cleveland, June 12-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Cleveland, Sept. 25-26.

AMERICAN CONGRESS OF OBSTETRICS AND GYNECOLOGY, Hotel Statler, New York City, May 14-19.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Netherlands Plaza Hotel, Cincinnati, Sept. 6-10.

AMERICAN HOSPITAL ASSOCIATION, Cleveland, Sept. 26-29.

AMERICAN MEDICAL ASSOCIATION, Atlantic City, N.J., June 6-10.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Copley Plaza Hotel, Boston, June 19-24.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Cleveland, Sept. 23-24.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Roanoke, Roanoke, Va., June 20-23.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, San Francisco, June 5-10.

ARKANSAS HOSPITAL ASSOCIATION, Marion Hotel, Little Rock, May 16-17.

ASSOCIATION OF CALIFORNIA HOSPITALS, Recreation Center, Santa Barbara, Nov. 17, 18.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel New Yorker, New York City, May 18-21.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CATHOLIC HOSPITAL ASSOCIATION, St. Louis, June 13-16.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

NATIONAL LEAGUE OF NURSING EDUCATION, Cleveland, May 2-6.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Somerset Hotel, Boston, June 10, 11.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Commodore Hotel, New York City, Nov. 7-9.

SOUTHERN CONFERENCE ON HOSPITAL PLANNING, Biloxi, Miss., May 19-21.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, May 6, 7.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

WASHINGTON STATE HOSPITAL ASSOCIATION, Olympia Hotel, Seattle, May 5, 6.

Opens Psychosomatic Clinic

NEW YORK.—Lebanon Hospital has opened a psychosomatic clinic for persons suffering from gastric ulcers, hypertension, asthma and allergies. Dr. Edward Kirsch, executive director of the hospital, stated that the establishment of the clinic rounds out the hospital's program of outpatient treatment in the psychiatric field.

NEWS...

Two of New York City's Oldest Hospitals Affiliate

NEW YORK CITY.—The oldest orthopedic hospital in the United States, the Hospital for Special Surgery, has affiliated with New York Hospital, the oldest general hospital in the city, and will build a 170 bed building for orthopedics and arthritis patients on land owned by New York Hospital.

The site of the new hospital is on East River Drive between 70th and 71st streets. The land will be transferred without monetary consideration to the Hospital for Special Surgery. The building will cost $3,000,000 and will take three years to complete.

Although the hospitals will continue as independent corporations, meeting their own operating costs and expenses, each will avail itself of the experience and facilities of the other.

The affiliation brings close together two of the oldest and best known of New York's hospitals. The Society of the New York Hospital, created by royal charter in 1771, has maintained a general hospital for 178 years. The New York Society for the Relief of the Ruptured and Crippled has maintained a hospital in New York City since 1863.

A.H.A. Announces Plans for September Convention

CHICAGO.—Evaluation of hospital service and its distribution, and a comparison of proposed plans to improve and extend hospital care, will receive major attention at the meetings and discussions of the American Hospital Association in Cleveland, September 26 to 29. The program planned represents a combination of the group sessions of previous years and the general meetings of the 1948 convention.

Meeting concurrently with the A.H.A. convention will be the second conference of Women's Hospital Auxiliaries. A special program is being planned for this group in addition to its participation in the association's general meetings.

Formal opening of the convention and exhibits will take place on Monday morning, September 26. An informal buffet and entertainment, "Fellowship Night," is scheduled for Monday evening under the sponsorship of the Ohio host committee. The annual banquet and the presentation of association and honors awards will be on Thursday evening, September 29.

A.H.A. Completes Plans for Laundry Institute

CHICAGO.—Final plans for its institute on hospital laundry management to be held here this spring have been announced by the American Hospital Association. Sessions will open at the Knickerbocker Hotel on May 16 and continue through May 20.

Students must be members of the association or employes of hospitals which are institutional members. Only administrators, laundry managers or persons having primary responsibility for the operation of a hospital laundry are eligible to apply for the institute.

The committee in charge of the institute has outlined five courses of study for the training period. They are costs, production, personnel, equipment planning and maintenance, and management aspects of laundry operation.

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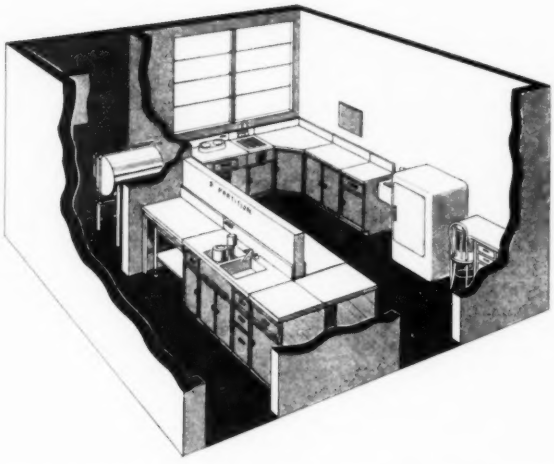

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GROUP 1 (FIXED)

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1a. 85-L-24DSS—Drawer Cupboard Unit with Special-Depth Top
2. 85L-D35—Table Top Units with 85X-27 Legs (3 Prs. Required)
3. 85L-72AS—Double Sink Unit
5. 85C-47—Counter Top Units with 85X-27 Legs (2 Prs. Required)
6. 85L2238M—Milk Formula Sterilizer
9. 85L-24AS—Sink Unit with Stainless Steel Grill
10. 85L-39—Corner Unit
11. Bulletin Board
12. 85L-35—Cupboard Unit
13. 85L-24D—Drawer-Cupboard Unit
14. Lavatory
18. 85ES-2—Electrical Duplex Plug Strip

GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle-Silver lustre Finish
8. 85P5363—Double Element Hot Plate
15. Refrigerator
16. 85P6238—Nurses' Desk—Silver lustre Finish
17. 85P6327AL—Chair—Silver lustre Finish
19. 85P6356—Milk Cart

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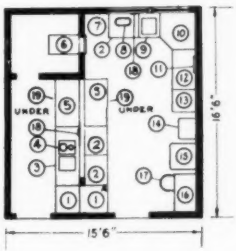

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NEWS...

New Jersey Hospital Engineers Organize

EAST ORANGE, N.J.—An association of executive engineers of hospitals in New Jersey was formed on March 17, it has been announced by Walter R. Booth, superintendent of buildings and grounds, East Orange General Hospital, East Orange, N.J., and first president of the new group, following a meeting held at Bonnie Burn Sanatorium, Scotch Plains, N.J.

The association was formed in response to the need for an organization that could focus its attention on the specialized problems of hospital maintenance and plant operation.

"Hospital power plants are operated differently from industrial plants," Mr. Booth asserted. "There is a need for a hospital power men's group which can hold panel discussions and exchange information on problems and methods in the field."

The association has adopted as its official name the Executive Hospital Engineers of New Jersey. Elected as trustees were George Baker of Beth Israel Hospital, Newark, N.J., S. B. Richards of Somerset Hospital, Somerville, N.J., and Fred M. Werder of Lutheran Hospital, Newark, N.J. Officers in addition to Mr. Booth are vice president, Arthur Dunbar of Elizabeth General Hospital, Elizabeth, N.J., and secretary, James Malloy, Englewood Hospital, Englewood, N.J.

Arkansas Hospital Opens Unit for Negro Patients

PINE BLUFF, ARK.—The fourth floor of the old building of Davis Hospital here has been completely renovated and opened as a department for Negro patients. A complete new lighting system, including fluorescent lights and a new nurses' signaling system, has been installed. All windows have been metal weather stripped and new venetian blinds have been installed. The walls in the corridors and some of the rooms are painted a pale green with white woodwork and ceiling. Other rooms were painted light blue with white trim. All beds have bed lights instead of overhead lighting.

For the first time, the hospital will have a fully equipped Negro labor room, delivery room, and nursery with eight bassinets and an incubator. Meals are prepared in the main hospital kitchen and carted to the new department in steam tables. The department has 25 beds.

Opens New Building With Gift From Bingham Fund

BOSTON.—The Farnsworth Building, to be opened this month by the New England Medical Center Hospital, is a gift of the Bingham Fund, money from which has provided complete medical service through 39 regional and small town hospitals in Maine and Massachusetts. The new building, or wing, has 150 beds and six operating rooms.

In the Bingham program today there are 33 outpost hospitals affiliated with the Central Maine General in Lewiston and the Eastern Maine General in Bangor. Others are in Massachusetts.

The entire plan has cost millions of dollars, but no building or laboratory bears the name of Bingham. William Bingham II, the man who started it all, has preferred to build memorials to his friends.

NEWS...

Patient Steals Show at New England Meeting

(*Continued From Page* 120.)

through. The free, locally controlled hospital will disappear, boards will lose their control, the public will not be so well served."

Said Mr. Hamilton: "The American people are not yet ready to scrap the United States 'know-how' gained during 150 years of operating community hospitals." He further warned against accepting a program in line with the groping uncertainties of countries that got into such a mess that government ownership and finance was the only way out.

STAGE JOINT CONFERENCE

For the benefit of trustees of New England hospitals, a joint conference committee meeting was staged on the platform of the Georgian Room, Hotel Statler. Three members of the medical staff of Mount Auburn Hospital, Cambridge, met with three members of the board of trustees of the same hospital, in company with the director, Dr. Albert G. Engelbach, to discuss such matters as staff appointments, medical audits and expansion plans. The audience was even more audible at times than were the participants, seeking the answers to such questions as whether the hospital should attempt to control fees charged by doctors to private patients, and who should be responsible for giving anesthetics in the maternity section of a small hospital.

Hospital auxiliaries, for many years well organized in Boston, are now being set up on state and national levels. Mrs. Amos F. Dixon, president, New Jersey Association of Hospital Auxiliaries, told a large audience of women from hospitals scattered throughout New England all about it. No small part of the value of such an organization will be in the exchange of ideas and experiences.

The ultimate success of auxiliaries, as Dr. Madison B. Brown, executive vice president, Roosevelt Hospital, New York, sees it, depends upon a well defined program with mutual understanding and appreciation on the part of the hospital administrator and the board of trustees and a deep, lasting interest in their job on the part of members of the auxiliary group.

Auxiliaries in action in both large and small hospitals were graphically presented by Mrs. Abraham Pinanski, past

Roof lights, siren, chrome hub caps, and white side wall tires optional at extra cost.

the best ambulance ever offered for exacting hospital service!

The 1949 *Superior-Cadillac*

This new vehicle is a true complement to the complete efficiency of the modern hospital, and its thorough, skillful, confidence inspiring services. There's every wanted feature in the Superior-Cadillac Ambulance for patient comfort and safety . . . every needed facility for administering to his well being. The combination of a chassis that is the standard for the world — Cadillac — with a coach that's the newest note in superb craftsmanship — Superior — is the ultimate in ambulances, the *best* ever built! Write for descriptive catalogue, showing models in full color.

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DeLuxe Dispensary Cabinet . . . for easily accessible storage of instruments, medication, linen, emergency first-aid equipment.

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president, Women's Auxiliary, Beth Israel Hospital, Boston, and Mrs. Mertie Witbeck, member, executive board, St. Luke's Hospital, Middleboro, Mass. Particular interest among such groups centers around the operation of coffee and gift shops, a fact that was plainly demonstrated in the discussion, led by Raymond P. Sloan, editor, The MODERN HOSPITAL, which only time and the gavel of William J. Donnelly, administrator, Greenwich Hospital, Greenwich, Conn., who presided, prevented from continuing long beyond closing time.

Thomas H. Creighton, editor, *Progressive Architecture*, New York City, had something of interest to pass along to those particularly interested in construction and maintenance. The cost of construction, while still spotty, is definitely trending downward. Mr. Creighton admitted to having seen decreases ranging from 5 to 20 per cent in current bids.

Both he and Everett W. Jones, vice president, The Modern Hospital Publishing Company, Inc., urged the need for revising obsolete restrictive building codes, codes which in many sections are adopted under pressure from labor unions and are designed to protect union jobs.

Patients can be cured faster and made to live longer and more comfortably through the hospital-to-home plan. Such has been the experience gained during the last two years at Montefiore Hospital, New York City. As described by Dr. E. M. Bluestone, director, this is a program by which facilities of the hospital are brought to the patient's home, instead of removing him to the hospital. An immediate benefit from such a program is the reduction in plans for bed expansion, which has so occupied the minds of hospital authorities during recent years.

Similarly significant statements on a wide variety of topics were advanced and considered for discussion throughout the three-day meeting, which, by the way, was the largest in point of attendance ever recorded in New England. The total count was substantially over 4000.

And yet, through all of these ruminations, there lingered in the memories of every man and woman who attended the opening session the voice of a little old lady, who asked of hospitals for herself and other patients merely kindness.

Name New Officers

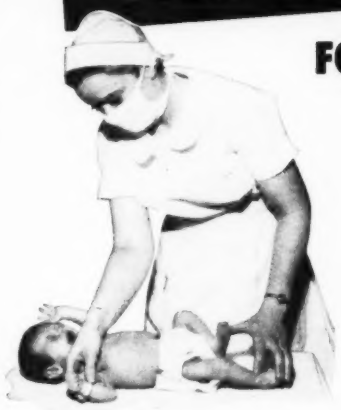
Newly elected officers of the New England Hospital Assembly for the coming year are: president, Lester E. Richwagen, Mary Fletcher Hospital, Burlington, Vt., who succeeds Dr. Engelbach; vice president, Paul J. Spencer, Lowell General Hospital, Lowell, Mass.; treasurer, Dr. Gerald F. Houser, Faulkner Hospital, Jamaica Plain, Mass., and secretary, Theodore F. Childs, Brockton Hospital, Brockton, Mass., succeeding Mr. Spencer. Dr. Engelbach, Charles Wynne, Waterbury, Conn., and Oliver G. Pratt, Providence, R.I., were appointed trustees.

The following officers were elected by the Massachusetts Hospital Association for the coming year: president, Dr. Norbert A. Wilhelm, Peter Bent Brigham Hospital, Boston; vice president, Paul J. Spencer, Lowell, Mass.; treasurer, Dr. Warren F. Cook, Boston, and secretary, Dr. Gerald F. Houser, Jamaica Plain, Mass.

HERE IS THE LATEST ADVANCE IN

IDENTIFYING BABIES

FOR YOUR HOSPITAL!



In less than 3 months we find more than 10% of the hospitals are today using the Presco Simplified Baby Identification System . . .

This is the first new and practical system of infant identification since the introduction of initialed beads. The advantages of this system over any other are outstanding. It fits into any hospital procedure . . . gives FULL information, mother's name, address, name of physician, date of baby's birth, and space for mother's finger print (if desired). Made from soft pliable (non-irritating) plastic (polyethylene.)

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- Makes the NURSE'S JOB EASIER.
- A beautiful keepsake for the mother.
- Merely write information on card and slip in position.

- Positive Identification with fool-proof snap-on self-locking fastener.
- Cannot come loose or slip off.
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- Mothers buy the bracelet; thus, hospital makes a profit.
- Easy to clean in water or alcohol.

COMPLETE KIT MAKES 144 BRACELET-ANKLETS

This plastic kit (lucite) contains all necessary materials, including: 144 complete bracelet-anklets (72 blue and 72 pink), 1 pair 4½" (chromed) surgical scissors, 2 pencils.....$59.75
Refills are packed as follows: 144 complete bracelet-anklets (72 blue and 72 pink).....$43.20

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NEWS...

"Self-Help" Units Installed in Massachusetts Hospital

BOSTON.—Peter Bent Brigham Hospital is installing 32 "self-help" room units, which will encourage patients to do as much as they can to serve themselves.

The units, designed by Frederick E. Markus and Paul F. Nocka, graduates of Massachusetts Institute of Technology, resemble pullman car roomettes. At the head of the bed are buttons for controlling the daylight and artificial illumination. In addition to the bedside table is a cabinet, and there is a two-way communication system between bed and the nurses' desk in the corridor.

The units are expected to cut down the nursing routine drastically and thus to bring about a reduction in rates. Savings to the hospital will come largely from a 30 per cent reduction in floor area per room.

The hospital trustees voted to use a $250,000 privately raised fund to proceed with the project.

No Class A Mental Hospitals, Speakers Say

(*Continued From Page* 122.)

from the public, and we have first to educate the public in the nature and needs of mental troubles," Dr. Menninger concluded.

Dr. Edward A. Strecker, professor of psychiatry at the University of Pennsylvania School of Medicine, held out small hope for those who would use brain surgery in mental illness.

In examining thousands of persons, Dr. Strecker found only 18 for whom he recommended psychosurgery.

Even among those who appeared much helped by the operation, he said he "suspected that something has been taken away psychologically which cannot be put back.

"In successful cases, individual mental functions that are separately tested show no loss, and the patient is certainly infinitely better off than before the operation. However, I have the feeling that in spite of the fact that separate function may test normally, yet there has been some loss, since I believe that human personality is greater than the sum of its parts."

All other methods must have failed before surgery is attempted, in Dr. Strecker's opinion. Patients with strong hallucinatory phenomena are most likely to be helped.

About nine-tenths of the mental hospitals in the country are using some form of shock therapy, Dr. Granville Jones, superintendent of Eastern State Hospital, Williamsburg, Va., told the 150 persons attending the institute. One-fourth of the remaining institutions, chiefly private, are not using shock because they don't believe in it, preferring psychotherapy. The remainder would use shock if they had the money and personnel to administer it. These figures come from a nationwide survey.

Dr. Jones regards it as tragic that so many patients receiving either insulin or electro-shock are not receiving any follow-up psychotherapy because of the lack of psychiatrists. The shock treatment, he relates, merely relieves acute symptoms and makes the patient acceptable to psychotherapy. Shock therapy acts both to repress the patient's symptoms and to intensify the repressions.

In the opinion of most of the 370 hospitals covered in this survey made by the National Committee for Mental Hygiene, insulin shock is the most useful treatment for schizophrenia, the

NEWS...

largest problem in mental illness. However, because of limited budgets, hospitals are using electro-shock because it requires less personnel and is much less expensive.

Dr. Winfred Overholzer, superintendent of St. Elizabeths Hospital, Washington, D.C., declared that the states "most notorious for the neglect of mental patients" are those where there is political control of mental hospitals, with staff appointments made on the basis of partisan politics.

ABOUT PEOPLE

(*Continued From Page 78.*)

A. James Behrendt has resigned as director of Olney Sanitarium, Olney, Ill.

T. J. Newland has been appointed administrator of the new Minnie G. Boswell Memorial Hospital, now under construction at Greensboro, Ga.

Edna Hindman, administrator of Grove City Hospital, Grove City, Pa., since 1939, has resigned. She had been associated with the hospital since 1932.

Mae H. Gutekunst has resigned as administrator of Mission Hospitals, Huntington Park, Calif., to accept a similar position with the Seward Sanatorium, Seward, Alaska.

W. A. McAlexander has been appointed administrator of the Clark County Memorial Hospital, Jeffersonville, Ind. He took his resident training at the Louisville General Hospital and Waverly Hills Sanatorium, which are under the direction of the Louisville and Jefferson County Board of Health. Mr. McAlexander will receive a degree in hospital administration at Northwestern University in June.

Donald S. Jackson has been appointed assistant administrator, Hackensack Hospital, Hackensack, N.J. Mr. Jackson was formerly superintendent, Brightlook Hospital, St. Johnsbury, Vt. He will be succeeded at Brightlook by **Ralph Perkins.**

William H. Pragnell, formerly superintendent, Mt. Vernon Hospital, Mt. Vernon, N.Y., has been appointed administrator, Elizabeth A. Horton Memorial Hospital, Middletown, N.Y.

Department Heads

Virginia Lowe is the new director of nurses at Wyoming Valley Homeopathic Hospital, Wilkes-Barre, Pa. She previously had served at Bloomsburg Hospital, Bloomsburg, and at Hahnemann Hospital, Philadelphia.

Lawson A. Morgan, assistant purchasing agent at Johns Hopkins Hospital, Baltimore, for two years, has been appointed purchasing agent for Mountainside Hospital, Montclair, N.J. Mr. Morgan served for 23 years in the hospital corps of the U.S. Navy, retiring with the rank of lieutenant (senior grade).

Mrs. Daphne Weston has been appointed superintendent of nurses at Laramie County Memorial Hospital, Cheyenne, Wyo. She was formerly an instructor at the Mary Lanning Hospital School of Nursing, Hastings, Neb.

Henry F. Bristowe is now public relations staff man at St. Catherine's Hospital, Omaha, Neb. He was formerly assigned to a similar post at Creighton University.

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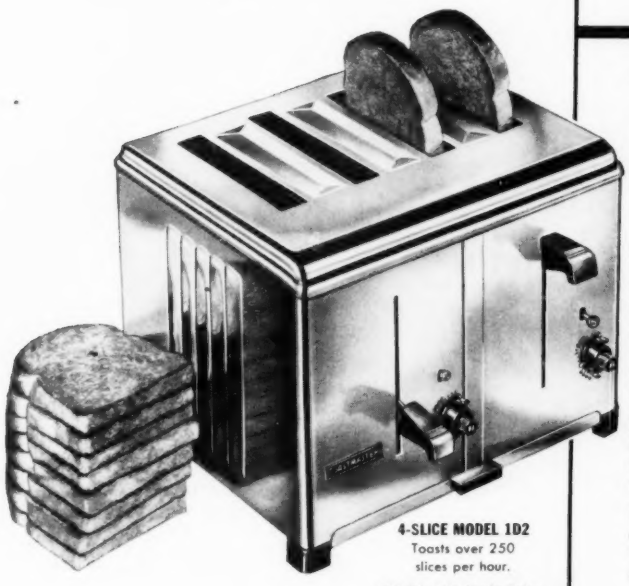
to suit your needs!



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NO MATTER HOW MUCH toast you use, you'll find the "Toastmaster" Toaster fits your needs. There are six sizes that pop up from 125 to 1000 slices per hour—from 2 to 16 slices per minute!

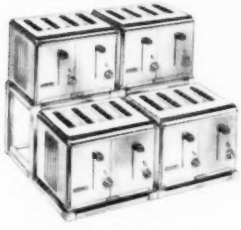
AND EVERY SLICE is perfect. There's no scraping, no re-toasting, no time or bread wasted. You'll save, too, on electricity. The "Toastmaster" Toaster is completely automatic. It uses current only while toasting . . . and each pair of slots is individually heated.

THERE'S NO WATCHING, no waiting. The operator puts in the bread, pushes the lever down, and is then free for other duties. When done to perfection, toast pops up automatically.

RUGGEDLY BUILT, the "Toastmaster" Toaster is designed for heavy-duty, institutional use. Its thick chromium-plated finish is durable and easy to keep clean.

YOU'LL BE SURPRISED at the time and steps that can be saved by putting a "Toastmaster"* Toaster on diet-kitchen duty. More and more hospitals are supplementing their main-kitchen toasters in this way. The result is less time spent on food service—more, on other tasks.

A Toaster for every Hospital Need!



FOR THE MAIN KITCHEN

The 16-slice, Model 4-1D2-D (left), is ideal for hospital main kitchens. That's because it has plenty of toasting capacity—pops up over 1000 slices per hour!

$410.00, Fair Trade Price.
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FOR THE DIET KITCHENS

The 2-slice, Model 1BB4 (right), is perfect for diet kitchens. It pops up over 125 slices of toast per hour. Equipped with cord to plug into any wall outlet.

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AUTOMATIC POP-UP TOASTERS

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TOASTMASTER PRODUCTS DIVISION
McGraw Electric Company, Elgin, Ill.

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My Dealer's Name.....

Arthur J. Shean Jr. has been appointed purchasing agent at Springfield Hospital, Springfield, Mass.

Dr. Myron M. Weaver, assistant dean of medical sciences at the University of Minnesota, has been named dean of a school of medicine to be established at the University of British Columbia, Vancouver. Although the school will not be opened for instruction until the fall of 1950, Dr. Weaver will assume his new post July 1.

Mildred McFerren has been appointed director of nursing service and school of nursing at Grace Hospital, Detroit. Miss McFerren's post at Queen's Hospital, Honolulu, Hawaii, will be filled by **Mary Vida Cheek,** who has just completed her master's degree at the University of Washington.

Mrs. Sahra S. Rapp is now director of the department of social work at Boston City Hospital, Boston.

Mrs. Miriam F. Leslie has been appointed director of nurses at Claremont General Hospital, Claremont, N.H.

Trustees

Edwin S. S. Sunderland has been elected president of St. Luke's Hospital, New York City, to succeed **Lincoln Cromwell,** who had held the office since 1938. Mr. Cromwell will continue to serve on the board, of which he has been a member since 1919.

Miscellaneous

Dr. James A. Shannon of the Squibb Institute for Medical Research, New Brunswick, N.J., has been appointed associate director in charge of research for the National Heart Institute.

Donald E. Porter has been named secretary of the tuberculosis division of the New York Tuberculosis and Health Association, succeeding **G. Donald Buckner.**

Charles O. Auslander was reappointed by the College of Physicians and Surgeons of Columbia University to conduct a series of eight weekly lectures on hospital purchasing this spring. Mr. Auslander was assistant director in charge of purchasing at Michael Reese Hospital, Chicago, before going to New York in 1947 and has lectured at Northwestern University on purchasing problems of hospital administrators.

William E. Kramer, purchasing agent at St. Mary's Hospital, Rochester, N.Y., is serving as regional coordinator of purchases for Emmitsburg Sisters of Charity, Emmitsburg, Md.

Olof Z. Cervin, architect of Rock Island, Ill., has retired from active practice. He will be available for consultation and advice to a limited number of clients.

Hugh J. McGoldrick has been appointed director of Michigan's State Office of Hospital Survey and Construction to succeed **James L. Dack.**

Deaths

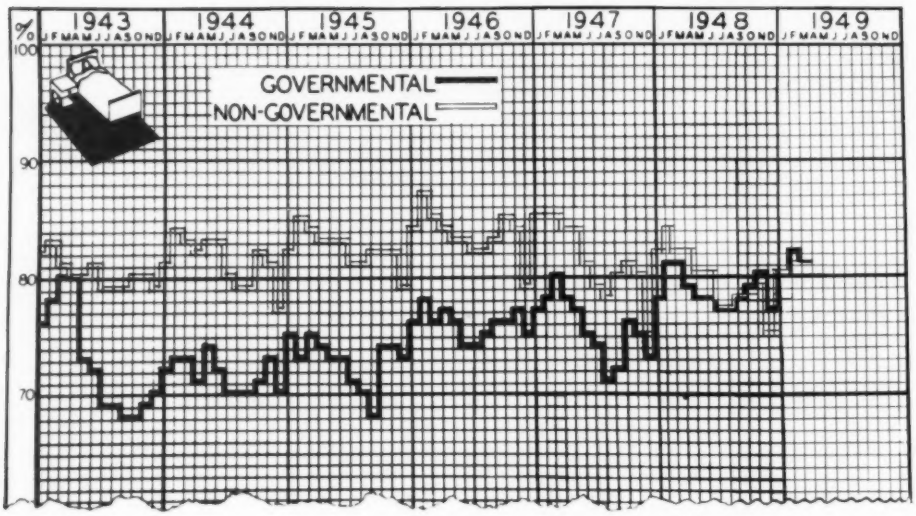
Dr. Charles C. Popplestone, superintendent, Central Maine Tuberculosis Sanatorium, Fairfield, Me., was killed in an automobile accident in Waterville. Dr. Popplestone was formerly on the staff of the Pratt Diagnostic Hospital and the faculty of the Tufts Medical School, Boston.

Dr. W. H. Barker, 42, assistant dean of Johns Hopkins University School of Medicine, died March 27 after an illness of two months.

Sister Mary Rita McGrath, R.S.M., manager of the laundry at St. Catherine's Hospital, Omaha, Neb., for many years, died in March.

Dr. Louis E. Hanisch, medical director of Lutheran Hospital, Omaha, Neb., died suddenly on March 13. Dr. Hanisch served as first president of the Omaha Hospital Council.

Voluntary Hospital Occupancy Remains Level



Voluntary hospitals reported occupancy of 80.8 per cent for March, just about level with the preceding month, but two points lower than the figure reported for the same period last year. Governmental hospitals in March showed a slight decrease from February (81.1 as against 81.5 per cent). This is still above the occupancy reported in March 1948 of 80.6 per cent.

Hospital construction costs for the year to date totaled $165,329,394. For the latest period, March 15 to April 15, 61 new projects were reported, with 55 reporting total costs of $37,959,605. Of these 17 were new hospitals, 16 of which reported costs aggregating $9,096,702.

G. M. S. Veterans Hospital, Omaha, equipped with 1,659 fine Fenestra Fencraft Windows. Architect: Ellerbe & Co., St. Paul, Minn. Associate Architect: Leo M. Daly, Omaha; Contractor: Peter Kiewit Sons Co. & Associates, Omaha.

Why this Omaha Veterans Hospital is using 1,659 FENCRAFT WINDOWS

Filling this big hospital from stem to stern with daylight and a constant flow of fresh air is a job Fenestra* Fencraft Windows are designed to do.

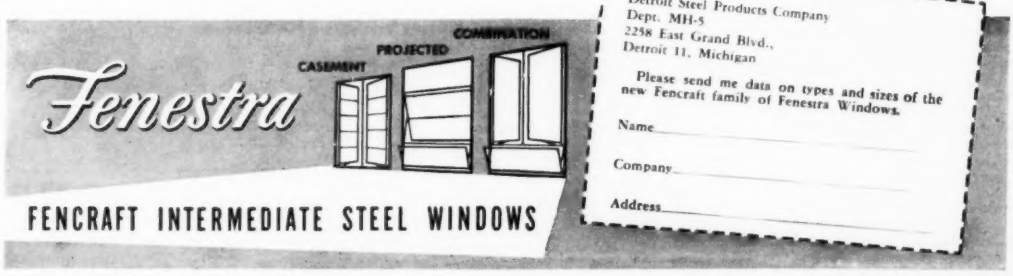
They bring in *extra* daylight simply because they have more glass area than most windows the same size. Swing leaves reach out to bring in breezes. Open-in sill vents provide controlled ventilation even in bad weather . . . and guard against drafts.

Staff people like Fencraft because window operation is so easy. Even for a nurse with one hand loaded down.

Slender muntins help carry out the sweeping lines of today's architecture. Fencraft Windows are made of high-quality casement sections of advanced design—fabricated into 51 different Projected Windows, 14 Casement and 36 Combination.

Designed to modular standards . . . they can be installed economically as single units or as whole walls of combined units. Maintenance costs are low—and screening and cleaning is done from *inside*. But perhaps even more important, standardized Fencraft Windows cost less to *buy*.

For further information toward a more beautiful hospital, please mail the coupon. *®



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Please send me data on types and sizes of the new Fencraft family of Fenestra Windows.

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"The best hospital floor is linoleum!"

"Our hospital was built twenty years ago. When we remodeled our out-patient department recently, we used our experience to good advantage.

"One thing we'd learned was the importance of the right floor. That's why we picked Armstrong's Linoleum. Its colorful, modern appearance lends dignity to all the rooms and at the same time gives the department a cheerful atmosphere that helps put people at their ease.

"We also picked Armstrong's Linoleum because it would stand up under heavy traffic and because it's so easy to keep clean. And the feature the staff really appreciates is its comfort underfoot. To me it all proves that the best hospital floor is linoleum."

"The best hospital floor is asphalt tile!"

"A small town hospital has two strikes on it from the start. You've got to show people you meet big city standards, and you haven't much money to do it with. That's why I think our committee was smart in picking Armstrong's Asphalt Tile for our floors. We got a modern floor and saved money, too.

"And yet our floors aren't 'ordinary.' We were able to work our own floor designs because asphalt tile just naturally goes down block by block.

"After four years of use our floors still look like new, and they're so easy to clean that our maintenance costs are even lower than we figured. For my money, Armstrong's Asphalt Tile was certainly the best choice."

AS MAKERS OF BOTH linoleum and asphalt tile, we'd like to step into this argument. There's no one "best" floor for all hospitals. It depends on the impression you want to create, the money you can afford to spend, the kind of subfloor you have.

Appearance is only one point to be considered in selecting the floor that's best for you. You should also take into account the conditions to which your floor will be subjected. Although asphalt tile costs less, linoleum is more resilient—it's quieter underfoot and has greater resistance to indentation. If oil or grease is likely to be spilled on the floor, linoleum or greaseproof asphalt tile is the choice. If your subfloor is a concrete slab in contact with the ground, you need asphalt tile to withstand the effects of alkaline moisture.

To get the floor that's best for you, weigh the advantages of one against the other. To help you choose, **drop us a card and we'll send you two books**—one about Armstrong's Linoleum and the other about our Asphalt Tile. To compare samples or actual floors in your locality, call your Armstrong flooring contractor. Write Armstrong Cork Company, 5705 State St., Lancaster, Pennsylvania.

ARMSTRONG'S FLOORS

LINOLEUM Ⓐ *ASPHALT TILE*

LINOTILE® ★ RUBBER TILE ★ CORK TILE

Hospital walls, above all else, should be sanitary . . . they should be sparkling clean . . . they should radiate uplifting cheer and brightness. All these requirements are met fully when walls are constructed of Natco Glazed Structural Facing Tile — the permanent, fireproof, low maintenance building tile. Economical to erect — Natco Structural Facing Tile walls stay like new, without repairs, refinishing or redecorating for the life of the building. Soap and water is the only maintenance needed.

Furnished in attractive mottled and straight light-reflecting colors. Now available in modular sizes — little or no cutting needed on the job, saving time, labor and material.

Write for descriptive catalog PF 47.

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"Carrara Glass is basic to our planning"

▼ In new construction as well as in remodeling plans, hospital authorities are depending upon Carrara Structural Glass, more and more, because of its fundamental high quality and proven excellence.

For here is a material that's ideal for operating rooms, laboratories, corridors, washrooms, kitchens, and private-room baths. It has permanence, beauty, high aseptic properties. And the restful, cheerful colors—of which there are ten—are pleasing to patients.

Carrara Glass has a reflective, flawless surface which is easy to keep clean and sparkling. A damp cloth will do. Chemicals, acids, water and grease cannot affect it. It won't absorb odors. Neither will it check, craze, fade, stain, nor change color with age. And for operating rooms, where a less reflective finish is required than standard Carrara Glass surfaces, a special Suede-Finish is available.

Make Carrara Glass basic to *your* planning. You'll find it worth-while. Consult your architect; he is thoroughly familiar with this structural glass. Meanwhile, fill in and return the coupon for free literature.

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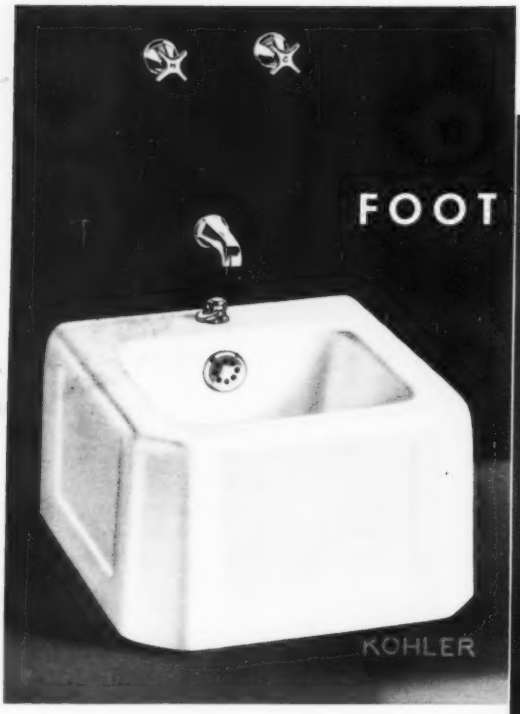
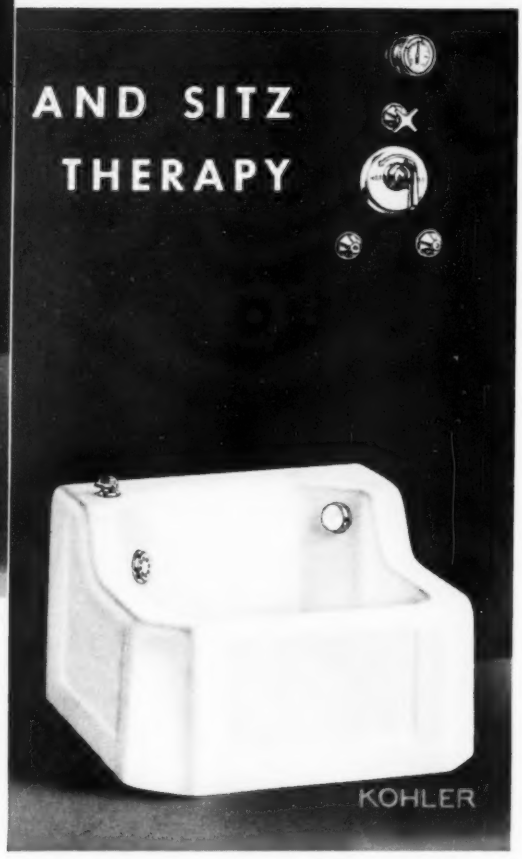


K-1115-A
Kohler built-in foot bath, complete with fittings.

K-1106-A
Kohler built-in sitz bath, complete with fittings.



These Kohler Baths meet rigid requirements

Kohler sitz baths and foot baths are the result of the special knowledge, long experience and careful workmanship which have made Kohler fixtures the choice of hospitals across the nation. Each of these baths is of iron, cast for strength and rigidity and coated with easy-to-clean, glass-hard Kohler acid-resisting enamel. The designs conform to the most exacting sanitary requirements, and the sturdy construction assures long service.

The sitz bath has a built-in ½" thermostatic mixer, dial thermometer, control valve and bell supply. The foot bath has built-in supply valves with over-rim spout. Each bath is equipped with a 1½-inch trip lever pop-up drain. All fittings are of chromium-plated brass, economical to maintain.

For information on Kohler continuous flow baths, hydrotherapeutic equipment, scrub-up and laboratory sinks, lavatories, siphon jet closets, service sinks and many other hospital fixtures, send for our special illustrated Hospital Catalog F.

Kohler Co., Kohler, Wis. Established 1873.

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PLUMBING FIXTURES • HEATING EQUIPMENT • ELECTRIC PLANTS

This air conditioning story is written for you

"Merely a Matter of Air" is a non-technical discussion of the various ways to air condition office buildings, hotels, hospitals, and similar structures which contain many small individual rooms.

Although written for the layman who is interested in the air conditioning of a multi-room building, it contains a great deal of material for the architect and consulting engineer, too. It covers the development of air conditioning from the first central systems, through early unit arrangements, up to and including UniTrane, the last word in ductless air conditioning.

The importance of the two-circuit UniTrane room units with their independent control of room temperature, room humidity and ventilation air is shown by direct comparison with earlier attempts to achieve this ideal arrangement.

Publication of this type of material is consistent with Trane's long-time policy of doing everything possible to remove the mystery from air conditioning. A reading of this bulletin by interested laymen places them in a much better position to understand the multi-room air conditioning recommendations of their architect and consulting engineer. We're glad to provide copies of "Merely a Matter of Air" for any such people.

THE TRANE COMPANY... LA CROSSE, WIS.

Manufacturing Engineers of Heating, Ventilating and Air Conditioning Equipment—Unit Heaters, Convector-radiators, Heating and Cooling Coils, Fans, Compressors, Air Conditioners, Unit Ventilators, Special Heat Exchange Equipment, Steam and Hot Water Heating Specialties. IN CANADA, TRANE COMPANY OF CANADA, LTD., TORONTO.

New UniTrane air conditioning *eliminates all ducts*, uses compact individual room units to regulate temperature, ventilation and humidity.

helps the staff, too!

Doctors, nurses, and patients all need the quiet that Sanacoustic* Ceilings provide

The oft-prescribed therapy of "quiet" which does so much for hospital *patients* can be just as helpful to the nerves of a hard-working hospital *staff!*

That is why many hospitals today are installing Johns-Manville Sanacoustic Ceilings—modern, attractive, noise-quieting. Use them especially in the "noise centers"—in utility rooms, corridors and lobbies, nurseries, wards, and diet kitchens.

J-M Sanacoustic Units are *fireproof*—consist of perforated *metal panels* backed up with a highly efficient sound-absorbing element. They are easily kept clean and sanitary.

Another J-M acoustical product often specified for hospitals is Fibretone, a drilled sound-absorbing fibreboard. Especially preferred when the hospital budget for acoustical treatment is restricted.

You can learn more about these two efficient materials in a brochure entitled "Sound Control." Write Johns-Manville, Box 290, New York 16, N.Y.

*Reg. U. S. Pat. Off.

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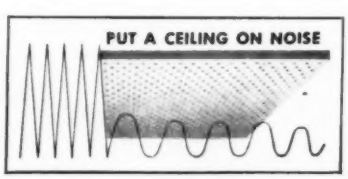
SANACOUSTIC CEILINGS



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FORGET PINHOLES OR CRACKS! Pyroxylin shades are made on such a closely-woven base, without filler, that they're impervious to cracks and pinholes. Better, *longer* wear!

COLOR SCHEMING — TAKE YOUR CHOICE! Match or harmonize Pyroxylin with any color plans...14 solid colors, including high-fashion pastels and decorator darks. Duplex combinations, also. Popular PRINTED shades.

VELVET-SMOOTH TO OPERATE! Columbia's shade rollers, made in Columbia's own plant, take care of that! Dependable, silent service throughout Pyroxylin's career.

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Canned Foods as a Source of Vitamin C

NO. 1 in a series of articles which summarize the conclusions about canned foods reached by authorities in nutrition research.

Vitamin C is known to play an important role in human nutrition. Severe deficiency of this factor results in scurvy. (1) Lesser deficiencies may affect many tissues of the body, but primarily the cementing substances of the blood vessels and teeth. (2)

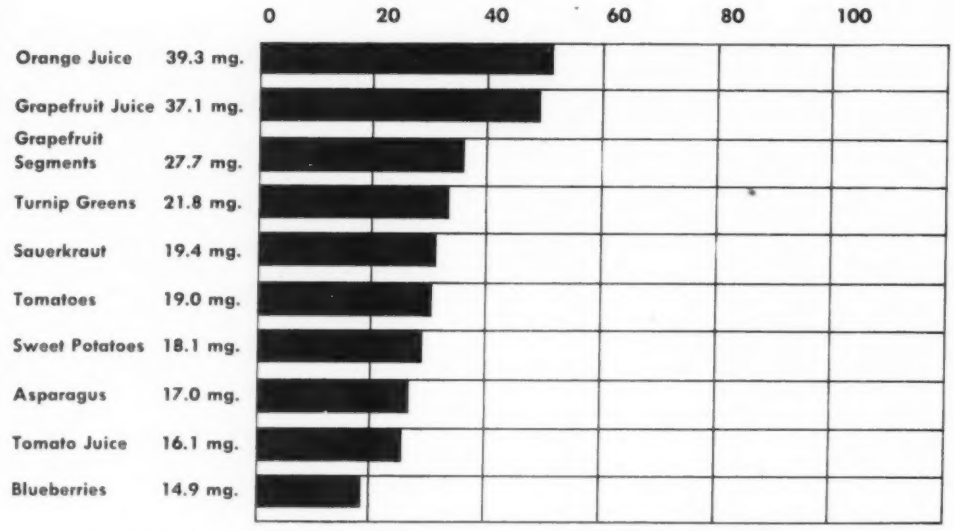
Vitamin C is widely distributed in nature. Augmented amounts tend to be found in actively growing parts of all plants. Citrus fruits, green leafy vegetables and tomatoes are excellent sources of the vitamin. (3)

Proper nutrition requires the presence of relatively large amounts of vitamin C, as compared with the other vitamins. Inclusion in the diet, however, of liberal quantities of fruits and vegetables, prepared in such a manner as to retain the major portion of the original vitamin C content, will supply the need for this vitamin. (4)

Commercially canned fruits and vegetables, as indicated in the table below, are effective antiscorbutic factors.

Percentage of Recommended Daily Allowance* in 4-oz. (113 grams) Serving

(Based on analysis of the entire can contents)



*Percentage based on Recommended Daily Allowance for moderately active man—75 mg. National Research Council

(1) 1939. The Newer Knowledge of Nutrition, McCollum, Orent-Keiles, Day. Page 421. MacMillan, New York.

(2) 1945. Chemistry and Physiology of the Vitamins, H. R. Rosenberg. Page 291. Interscience, New York.

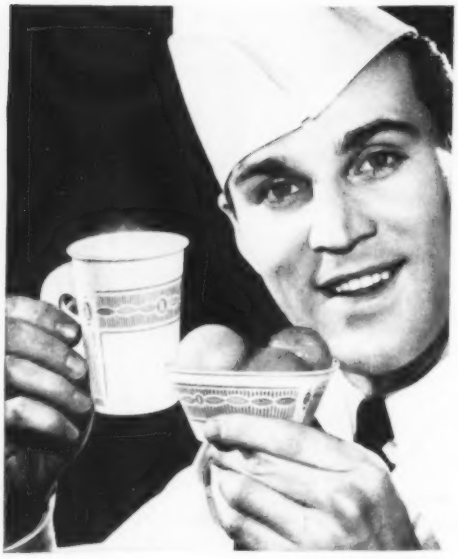
(3) 1943. Handbook of Nutrition, A. M. A. Council on Foods and Nutrition. Page 337. American Medical Association, Chicago.

(4) 1947. The Canned Food Reference Manual, American Can Company. Page 246. Rogers-Kellogg-Stillson, New York.

Greater Appeal

...AT LESS COST

Dietitians and hospital administrators are finding that Dixie Cups and Containers offer an improved method of food and drink service, which also effects many economies. Hot foods can be kept hot, cold foods cold, because of the paper's lower conductivity of heat and cold, and by using tight-fitting, freshness and flavor protecting Dixie lids.



SEE THESE ADVANTAGES OF DIXIE FOOD AND DRINK SERVICE

SMOOTHER— Fewer delays in kitchen resulting from clutter of unwashed dishes or help absences. Fewer complaints resulting from beverages and foods reaching patients at distasteful temperatures.

QUICKER—Speeds distribution of bed-side meals and between-meal feedings — Dixies are always ready for instant use. Trays are lighter — less fretful waiting to be served.

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THRIFTIER—*Saves time, labor*—Greatly reduces dishwashing. Cuts clean-up, sterilizing, storing time by hours a day. *Saves food*—No waste through careless over-portioning. *Saves materials*—No soaps, detergents, hot water needed No breakage, calling for constant replacements.

In hospital feeding the trend is to

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St. Vincent's College SELECTS GAS for KITCHEN MODERNIZATION

Century-old "hot-top" replaced by modern Gas-fired stainless steel cooking tools

Kitchen Equipment furnished by Bernard Gloekler Corp., Pittsburgh

TRADITIONS of good food remain unchanged, but preparation and service have been streamlined by the installation of GAS and modern Gas Cooking Tools at this famous Benedictine Archabbey and College.

To provide for 200 Monks and a resident student body of 800, the staff of 34 European Nuns is responsible for preparing more than 3000 meals daily. In this volume cooking operation the stainless steel Gas Equipment offers many time-saving and work-saving advantages.

But equally important are the time-proved features of GAS which make it the ideal fuel for roasting, broiling, deep-fat frying, baking. At St. Vincent's bread-baking is a regular and important function for which 2500 bushels of wheat are required annually.

This same automatic control feature also permits the slow-roasting of meats to prevent shrinkage and retain all essential juices. But GAS can also be used for speed-cooking, and for the exact temperatures required in deep-fat frying of many kinds of food.

The GAS installation at this well-known Archabbey and College, located near Latrobe, Pennsylvania, has demonstrated the economy and efficiency of GAS and modern Gas Equipment. Call your local Gas Company and check the economies of volume cooking with GAS.

AMERICAN GAS ASSOCIATION

MORE AND MORE... THE TREND IS TO GAS FOR ALL COMMERCIAL COOKING

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Bank of Gas-fired stainless steel ovens and deep-fat frying unit

Gas-fired steam kettles and stock kettles

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PATIENT HOLMES: My, what a nice surprise! These beautiful roses, and a grand breakfast! (In hospitals, as in homes, Kellogg's cereals rate as favorites with youngsters and grownups alike.)

NURSE ROGERS: I'm surprised at how quickly Kellogg's Individuals help me get through breakfast. They're so easy to serve, so neat and sanitary, so well-liked by everyone. I'm a real Kellogg's fan.

DIETITIAN AYRES: Kellogg's help us lick two problems: giving patients the foods they like, plus giving them the nutrition they need. Kellogg's cereals do a perfect job—so flavorful *and* nutritious!

GRAND NUTRITION: All Kellogg's cereals either are made from the whole grain or are restored to whole grain nutritive values of thiamine, niacin, and iron. Grand nutrition—*plus* Kellogg flavor!

Be sure your wholesaler salesman keeps your assortment of Kellogg's complete at all times.

Made by Kellogg's—THE GREATEST NAME IN CEREALS

Battle Creek and Omaha

TUNA FISH AND
NOODLE CASSEROLE
IN LILY CUPS

Tuna fish, drained	24-13 oz. cans
Noodles	6 pounds
Tuna oil	1½ quarts
Flour	1½ quarts
Milk, scalded	3 gallons
Salt	3 tablespoons
Green peppers, chopped	1 pint
Onions, chopped	1 pint
Cheese, grated	2 pounds

Drain tuna, reserve oil for white sauce. Cook noodles in boiling salted water. Boil 10-15 minutes or until tender. Drain. Make a white sauce by mixing the tuna oil and flour; then add scalded milk and salt and cook until slightly thick. Cook the green peppers and onions in salted water till tender. Drain and add to white sauce. Arrange noodles and tuna fish in layers in Lily Nestrite. Cover with white sauce and sprinkle generously with grated cheese. Put about ⅛" water in shallow pan. Place Nestrites in pan. Bake in moderate oven, 375° F. for 20-30 minutes. 125—8 oz. servings.

BAKES IN TWO SHAKES... and so easy to make!

Yes! You can bake delicious casseroles in Lily* Nestrites! It's the quickest, easiest way in the world... no soaking, no scrubbing, no pots, no dishes. This tempting tuna dish takes just 20 minutes. Just fill, bake and serve... that's all! Convenient, baked-in-the-cup casseroles — another good reason why so many leading hospitals are switching to Lily Matched Hospital service. Drop us a card today... and we'll send you a dozen easy casserole recipes and a sample supply of cups.

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● Your service sets will sparkle with inviting cleanliness . . . and deliver lasting, steady-duty service . . . *when it's Vollrath Stainless Steel Ware!* The new design and sturdy construction of these Vollrath pieces typify the high quality and craftsmanship always associated with this *blue-and-white* trademark.

Call your Vollrath Ware jobber, or write us today for prompt service.

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You can always depend on Vollrath Ware for the essential line of advanced design and quality.

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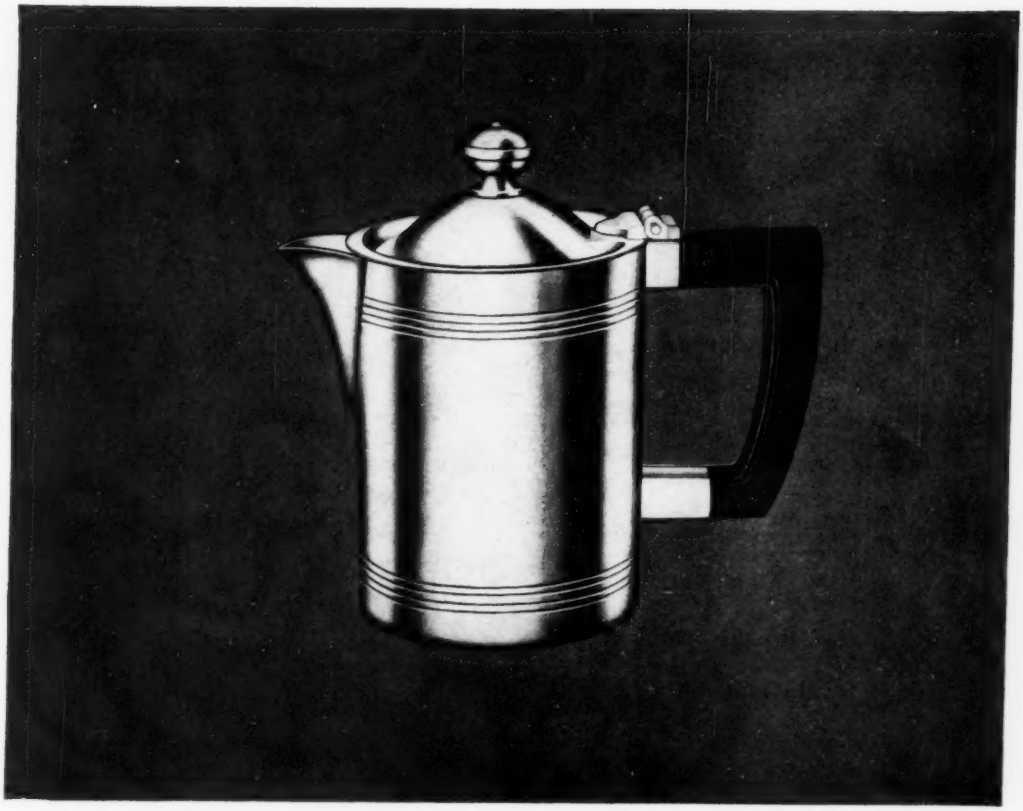

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ESPECIALLY FOR THE HOSPITAL!

STUDIES conducted by Wallace Silversmiths led to development of a holloware service "tailored" to the special needs of hospitals.

In designing it, consideration was given to ease of cleaning, durability, eye-appeal, price.

The new, improved coffee pot, for example, has straight-up-and-down sides for easier, thorough cleaning. Bacteria-breeding, inaccessible corners are eliminated. Another feature is the non-heat-conducting handle. Wallace hospital holloware is 18% nickel silver base, silver soldered and triple plated. It is durable!

Cost? Amortized over a period of a few years, Wallace holloware not only pays for itself, but gives you a dividend on your investment, in lowered replacement costs and in the added prestige and patient goodwill accruing to hospitals that use Wallace holloware.

For further details, consult your Wallace Supply Dealer, or write to us.

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For finest apples ever canned
And "Orchard Fresh"—use MONARCH brand.
They will not "break down" in the pie,
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They're picked and peeled and packed so fast,
We're sure you'll say that at long last,
You've found an apple in the can
That can't be beat—That's MONARCH brand.

Each pound goes farther—makes more pies.
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Just try this product—just one test
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MONARCH

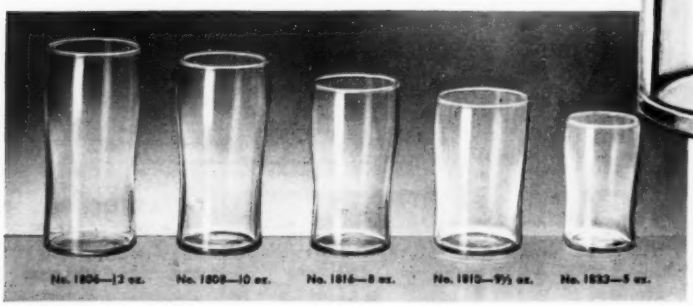
World's Largest Family of Nationally Distributed Finer Foods

REID MURDOCH, Division of Consolidated Grocers Corp., Chicago, Ill.

Meet Libbey's new

"COLUMBIAN" Tumbler Line

. . . a Heat-Treated companion to the famous Libbey Columbian Stemware!



ACTUAL SIZE
8 Oz. Hi-ball "COLUMBIAN" Pattern

CURVED GENTLY for sleek, smooth eye-appeal.

Yet straight enough to offer plenty of "display room" for an individual crest or design.

That's the mold from which we bring you the new, Heat-Treated "COLUMBIAN" tumbler.

Greater space for selling decoration is an "extra," of course—for "COLUMBIAN" has *all* of the typical Libbey Heat-Treated Tumbler advantages. It's lightweight, easy to hold . . . *lasts 3 to 5 times longer* than ordinary tumblers. Every one is backed by the amazing Libbey guarantee: "A new glass if the 'Safedge' ever chips."

Give "COLUMBIAN" an opportunity to show *you* its eye-appeal and durability. Request samples and prices from your nearest supply dealer or Libbey sales office—or write directly to Libbey Glass, Toledo 1, Ohio.

LIBBEY GLASS BOUNCE TUMBLERS

Libbey HEAT-TREATED

Libbey Glass, Division of Owens-Illinois Glass Company, Toledo 1, Ohio

MEAT...
and Physical Rehabilitation

Any marked loss of weight in the nonobese patient deprives the organism of a considerable amount of protein, apt to lead to severe protein deficiency. A weight loss of 5 Kg. does not appear large as such. Yet it is estimated that it may well entail a simultaneous loss of as much as 900 Gm.—or two pounds—of tissue protein,* taken from the scant protein stores of the body, from the muscles, liver and other viscera. Prevention of such large protein losses or rapid replacement of depleted protein stores is imperative. Nitrogen balance must be re-established as quickly as possible to promote local healing and general recovery in many surgical conditions, in severe burns, in metabolic disturbances, and following overwhelming infections.

Meat as the primary source of protein affords a number of special advantages in the period of actual dietotherapy as well as during recovery and rehabilitation. It is of excellent digestibility so that it can be easily eaten two or three times a day to satisfy increased protein requirements.

The appetizing taste appeal encourages simultaneous intake of other valuable foods, especially desirable in the presence of anorexia.

All meat is notably rich in biologically complete protein, from 17 to 20 per cent of its uncooked and from 25 to 30 per cent of its cooked weight. Furthermore, meat ranks with the best sources of B-complex vitamins and iron, important nutrient factors in physical rehabilitation.

---

*Meyer, K. A., and Kozoll, D.D.: Progress in the Treatment of Carcinoma of the Stomach and Esophagus, South Dakota J. Med. & Pharm. *2*:39 (Feb.) 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago...Members Throughout the United States

Answering many needs in a varied field

Nineteen years of clinical experience—reviewed in more than 480 published reports—show that short-acting Nembutal also answers many needs. Listed at right are 44 conditions in which it has been effectively used. Perhaps they may suggest new ways in which you can use the drug. Experience has shown that adjusted doses of short-acting Nembutal can achieve any desired degree of cerebral depression, from mild sedation to deep hypnosis. Dosage required is only about *one-half* that of many other barbiturates. Small dosage means less drug to be inactivated, shorter duration of effect, reduced possibility of "hangover," wide margin of safety and definite economy to the patient. Eleven different Nembutal products are available—all of them in convenient small-dosage forms. Write for the new booklet "44 Clinical Uses for Nembutal." ABBOTT LABORATORIES, North Chicago, Illinois.

44 of Nembutal's Clinical Uses

sedative

Cardiovascular
Hypertension[1]
Coronary disease[1]
Angina[1]
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[3,4]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[3,4]

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

hypnotic

Induction of Sleep

obstetrical

Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[5]

surgical

Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

pediatric

Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Nembutal alone or
[1]*Glucophylline® and Nembutal,*
[2]*Nembutal and Belladonna,*
[3]*Ephedrine and Nembutal,*
[4]*Nembudeine®,*
[5]*Nembutal and Aspirin,*
[6]*with scopolamine or other drugs.*

In equal oral doses, no other barbiturate combines QUICKER, BRIEFER, MORE PROFOUND EFFECT than . . .

Nembutal®
(PENTOBARBITAL, ABBOTT)

HAVE YOU TRIED Nembutal Sodium Capsules, Suppositories or Nembutal Elixir for preoperative medication?

Rugged Hospital Sheeting Offers Soft, Smooth Comfort

More comfort for patients . . . less work for the staff . . . savings for your budget, too! You get all these features in Du Pont's "Fabrilite"* hospital sheeting, Quality 3510-U.

Skilful blending of synthetic materials has made it possible. Suitable for use in ambulances and mortuaries as well as hospitals, "Fabrilite" is thin, soft and pliable . . . conforms to body position for maximum comfort. It resists cracking, peeling and sticking . . . resists stains of all types. Stands autoclave sterilizing (15 lbs. steam pressure for 20 minutes). "Fabrilite" has high resilience. It can be easily cleaned with mild soap solutions or sterilized with standard hospital disinfectants.

This outstanding Du Pont hospital sheeting is kin to the "Fabrilite" that so beautifully upholsters hospital lounges and restaurants, reception-room walls and doctors' offices. "Fabrilite" upholstery and "Fabrilite" sheeting are made to stand abuse . . . made to *last* . . . for overall savings in the budget.

Next time you buy hospital sheeting, ask your supplier to show you Du Pont "Fabrilite" Quality 3510-U. Comes in standard-size rolls of 50 yards, or half-size rolls of 25 yards, 36" width. Remember—for hospital sheeting with *more good features*—always look to Du Pont! E. I. du Pont de Nemours & Co. (Inc.), Fabrics Division, Fairfield, Connecticut.

*"**FABRILITE**" *is Du Pont's trade mark for its vinyl plastic-coated fabric and plastic sheeting.*

Du Pont Fabrilite

REG. U. S. PAT. OFF.

DU PONT

REG. U.S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

Information you will want concerning

Pen-Aqua

Bristol's **New Aqueous Repository Penicillin** with a **Booster** for higher initial blood levels—now being introduced and intensively promoted to doctors in your area.

What it is—Procaine Penicillin G, 300,000 units per cc., plus buffered Potassium Penicillin G, 100,000 units per cc., in combination for constituting an aqueous solution-suspension for intramuscular injection.

What it does—Soluble *Potassium Penicillin* is quickly absorbed within an hour following injection, thus providing a high initial penicillin blood concentration to overwhelm invading bacteria at the outset. Insoluble *Procaine Penicillin* is absorbed slowly, thus providing a repository effect which sustains therapeutic penicillin blood levels for 24 hours or more in approximately 90% of patients.

How to use it—The directed quantity of Water for Injection, USP, or other aqueous diluent, is introduced directly into the sterile PEN-AQUA vial, with thorough shaking before the withdrawal of each dose. A uniform suspension, which passes through the needle freely, is easily and quickly obtained. Suspensions retain their potency for one week under refrigeration. In the dry state, PEN-AQUA retains full potency for a year.

When to use it—In all conditions amenable to systemic penicillin therapy, in cc. doses corresponding in frequency with that employed with Penicillin in Oil and Wax—generally, one cc. each 24 hours, 12 hours in certain severe or refractory infections. PEN-AQUA is intended for intramuscular use only.

How supplied—In multiple-dose vials containing 1,500,000 units of Procaine Penicillin G, plus 500,000 units of buffered Potassium Penicillin G, with space provided for the introduction of 4.5 cc. of diluent; also in single-dose vials containing 300,000 units and 100,000 units of Procaine and Potassium Penicillins G, respectively, with space provided for the introduction of 1 cc. of diluent.

It is immediately available on order, direct or through your wholesaler.

Bristol
LABORATORIES INC
SYRACUSE, NEW YORK

Pen-Aqua *Bristol Laboratories' Trademark for Crystalline Procaine Penicillin G with Buffered Penicillin G Potassium for aqueous injection*

BRANCH WAREHOUSES AND ORDER DEPOTS

25 West 15th St., New York 11, N. Y.
66 Mangum St., N. W., Atlanta 3, Ga.
549-559 East Illinois St., Chicago 11, Ill.
625 Folsom St., San Francisco 7, Calif.

Natural Shock Absorbers

Like the strands of the spider's web, silk fibers are notable for their great elastic strength—a quality that makes them pre-eminent as suture material.

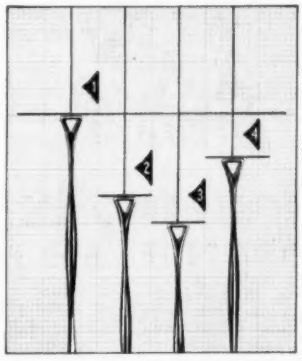
Silk sutures can be stretched 20% and retain their original strength. When tension is released, they return to approximately their original dimensions.

Their "shock absorber" quality helps prevent breakage when knots are tied; acts as insurance against knot slippage. Silk sutures reduce tissue strangulation during post-operative edema. Silk adjusts itself as tissues swell and shrink.

Champion Serum-Proof Silk Sutures are the non-absorbable sutures of choice—for elastic strength, dependability and perfection of finish. They are available from your regular supply house, or direct from the makers,

GUDEBROD BROS. SILK CO., INC., 225 W. 34th ST., NEW YORK 1.

TESTS SHOW ELASTICITY



(Fig. 1) An 0 gauge Champion-Paré Serum-Proof Silk Suture prior to stress. **(Fig. 2)** The same, suspending a 5 lb. weight. **(Fig. 3)** The same suture, suspending a 10 lb. weight. **(Fig. 4)** After weights are removed.

CHAMPION-PARÉ
SERUM-PROOF SILK SUTURES by

Gudebrod

Also makers of: **Dermal, Cotton and other Champion Sutures**

Of immediate importance to you ...the HOSPITAL PHARMACIST

TEL-O-SEAL CONTAINERS
For I.V. solutions. Permits routine sterility check during storage period. Available in 350, 500, 1000, 1500 and 2000 ml. sizes.

In spite of the current spiral of inflationary costs, your skill plus Fenwal Equipment and Technics can effect drastic reductions in the cost of intravenous solutions for your hospital.

POUR-O-VAC CONTAINERS
For sterile water and saline technics. Available in 350, 500, 1000, 1500, 2000 and 3000 ml. sizes.

FENWAL ASSURES SAFETY, ACCURACY AND CONVENIENCE

1 Standardized equipment and technics which cover every phase of I.V. therapy; sterile water procedure; preparation of antibiotics in solution.

2 Specially designed PYREX Brand glass containers from 75 ml. to 3000 ml. Six practical sizes that accommodate interchangeable hermetic seals.

3 Reusable vacuum closures.

4 Automatic washing and filling equipment and accessory apparatus.

5 A background of 10 years of satisfactory operation in many leading hospitals throughout the world.

FENWAL offers to hospital pharmacists, by virtue of their scientific training, experience and position, the means of effecting substantial and immediate economies for affiliated hospitals . . . and in addition . . . the opportunity to enhance the prestige of their pharmacy services.

AMP-O-VAC—
The Reusable Ampule
Reduces the waste of novocaine and similar medications by permitting periodic withdrawals as required without exposing balance of contents to air. Container and hermetic closure may be repeatedly sterilized. Available in 75 ml. size only.

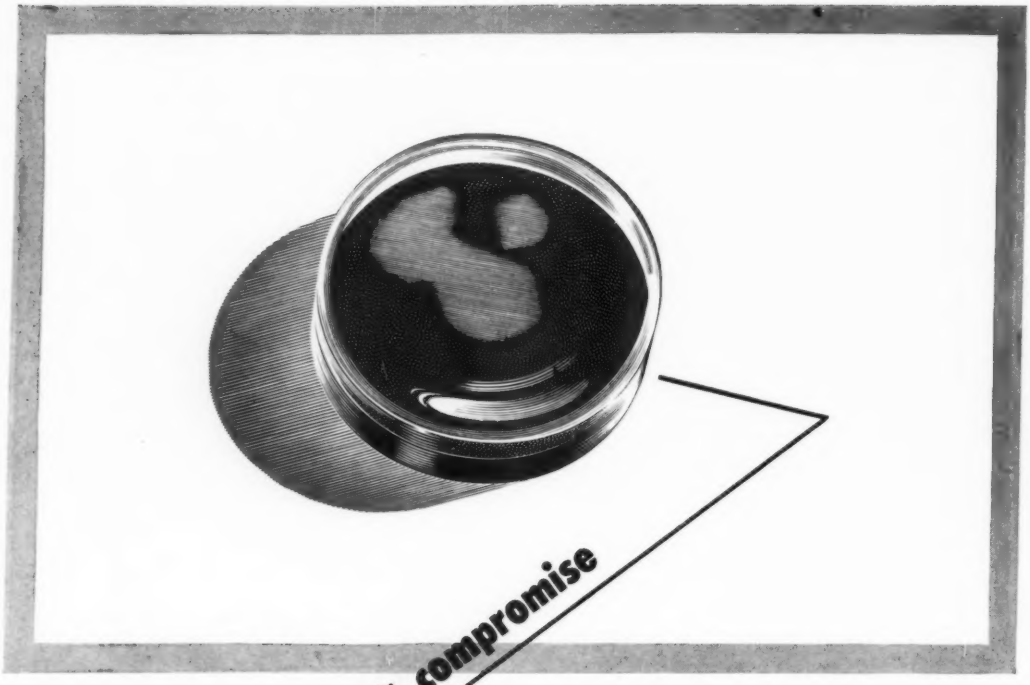
• Fenwal representatives are equipped to assist you in the selection, installation and operation of equipment best adapted to meet the volume requirements of your hospital.

HEADQUARTERS FOR SCIENTIFIC GLASS BLOWING, LABORATORY AND CLINICAL RESEARCH APPARATUS, REAGENT CHEMICALS

ORDER TODAY or write today for further information

MACALASTER BICKNELL COMPANY

243 Broadway Cambridge 39, Massachusetts



Bacteria don't compromise

Nothing less than complete antiseptic action is satisfactory in surgical procedures. That is why such painstaking research preceded the development of Zephiran.

Pick any of the important attributes of a good antiseptic you want . . . prompt effectiveness, economy, safety . . . and you will find it in Zephiran chloride.

Zephiran chloride actually kills bacteria, it doesn't just inhibit them. It's fast in its action, too—faster than many other antiseptics. What's more, Zephiran is adequately germ*icidal* and less toxic than the mercurials.

For an antiseptic that is useful everywhere in hospital and office practice, SPECIFY

ZEPHIRAN® CHLORIDE

EFFECTIVE, SAFE, ECONOMICAL ANTISEPTIC

Supplied as: Aqueous Solution 1:1000, bottles of 8 fl. oz. and 1 U. S. gallon. Tincture 1:1000, tinted and stainless, bottles of 8 fl. oz. and 1 U. S. gallon. Concentrated Aqueous Solution 12.8%, bottles of 4 fl. oz. and 1 U. S. gallon (1 oz. = 1 U. S. gallon 1:1000 solution).

Zephiran, trademark reg. U. S. & Canada, brand of benzalkonium chloride (refined).

Winthrop-Stearns INC.

NEW YORK 13, N. Y. • WINDSOR, ONTARIO

Help Make Economical Hospital Administration Possible

Back in the early thirties when Latex Gloves were first introduced, hospital people were skeptical. They had become so accustomed to the weight and color associated with Brown Milled Gloves that they could not believe these tissue thin, translucent latex things could give adequate protection. Surgeons, especially, were suspicious. And purchasing agents would take one look at the price and say, "Listen, don't you know there's a depression on?" Manufacturers published test after test proving that Latex gloves, even at their higher price, were more economical because you could autoclave Latex gloves again and again and they would still be stronger and better than brand new, fresh Brown Milled Gloves. But habit was habit and color was color and weight was weight and a dollar was a dollar. And so Brown Milled Gloves continued to hold the market.

Then came Brown Latex Gloves. And hospitals began to nibble. They discovered for themselves that Latex Gloves, in spite of their thinness, were actually stronger; that their very thinness made them more comfortable and gave the surgeons greater touch sensitivity; that they would actually outwear Brown Milled Gloves enough so that they cost less to use. So Latex Gloves began to gradually replace Brown Milled Gloves.

Today, while some hospitals still use Brown Milled Gloves, the vast majority are using Latex Gloves. They have sold themselves.

We have been advocating the use of Latex Gloves since they were first introduced. The quality of the Latex Gloves we market has had its share in demonstrating the economy — protection — utility value in Latex Gloves. The "Will Ross Latex Gloves" (clear) and the "Kenwood Brown Latex Gloves" (brown) are recognized values throughout the hospital field. They keep step with progress. They help make economical hospital administration possible.

WILL ROSS, Inc.

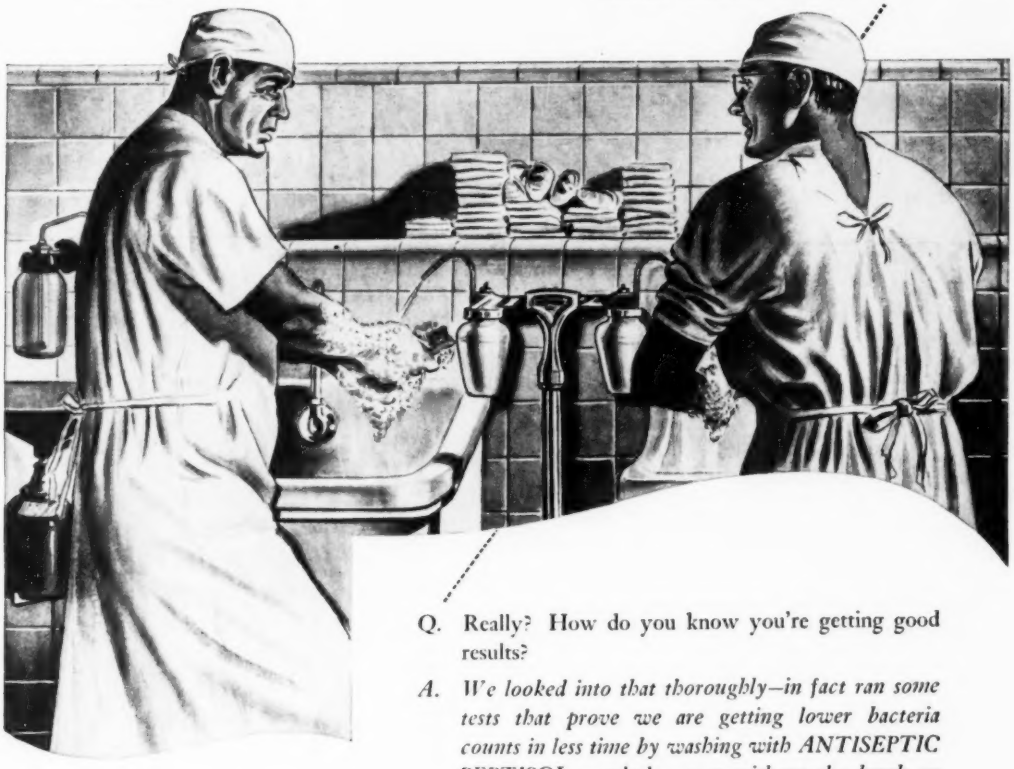
When you need gloves be sure to consult your Will Ross representative. He has a very interesting proposition for you.

Manufacturers and Distributors of Hospital and Sanatorium Supplies and Equipment

MILWAUKEE 10, WISCONSIN

Q. THIS SCRUB ROUTINE SURE GETS ME DOWN, JIM! After two or three scrubs in one day my hands and arms are raw—not to mention the time I lose!

A. Why don't you look into that new antiseptic liquid soap we are using at the university hospital? Over there we wash only six minutes, and brushes and alcohol rinses are unnecessary.



Q. Really? How do you know you're getting good results?

A. We looked into that thoroughly—in fact ran some tests that prove we are getting lower bacteria counts in less time by washing with ANTISEPTIC SEPTISOL regularly—even without the brush or alcohol.

Q. Say! I think I've heard of that product. Doesn't it contain that compound G-11* which I've seen reported in the medical journals?

A. That's right, and the beauty of it is that it's not harsh on the hands. We haven't had any trouble with irritation since we have standardized on it.

Q. I can see its advantages . . . I'm going to talk to our surgical supervisor about it and recommend that it be considered at our next staff meeting.

* Trade mark of Sindar Corporation

ANTISEPTIC SEPTISOL
CONTAINING HEXACHLOROPHENE (G-11)
IS A CONCENTRATED LIQUID ANTISEPTIC SOAP FOR SURGICAL AND HOSPITAL USE

It is a product that permits *considerable simplification* of existing methods of preoperative scrubbing, yet *markedly* increases bacteriological cleanliness. There is ample evidence to support this statement.

We invite your inquiries.
ADDRESS VESTAL, INC., DEPT. AS
4963 MANCHESTER, AVE.
ST. LOUIS 10, MO.

VESTAL INC. ST. LOUIS • NEW YORK

The New York Hospital-Cornell Medical Center

1,445 BEDS
in continuous use

A private room

Founded in 1771 as a non-profit institution supported by gifts, The New York Hospital has grown today to an enormous citadel of healing, serving the City of New York. The year 1947 saw over 25,000 bed-patients receive the finest treatment that modern science affords. In keeping with the high standards of this institution are the UTICA sheets that are used—strong to stand the hard wear of constant changing and laundering, yet always soft and comfortable.

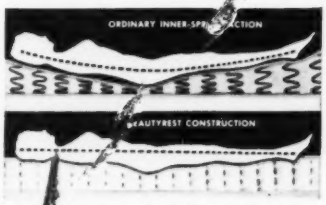
UTICA SHEETS

WOVEN EXTRA STRONG . . . TO WEAR EXTRA LONG

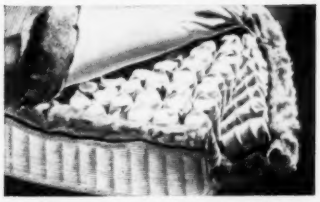
UTICA AND MOHAWK COTTON MILLS, INC., Utica 1, New York • Selling Agents: Taylor, Pinkham & Co., Inc. 65 Worth Street, New York 13, N. Y. • 300 West Adams Street, Chicago 6, Ill. • 605 Market St., San Francisco 11, Cal.

"My records prove *Beautyrest* is the best buy for my budget"

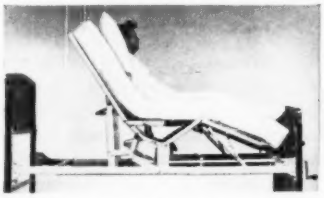
No wonder, Mr. Administrator—check these quality features found in no other mattress. They are your assurance of long life—economy of upkeep.



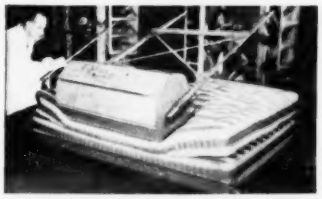
See those individually pocketed coil springs. They're exclusive with Beautyrest. Notice how each one operates independently with no wearing "hammock" sag. They're made of finest spring steel—can stand up to the extra hard wear in hospital use. (The independent action of Beautyrest coil springs is the big reason for its firm, uniform support, etc.—the best for the patient's rest and recuperation.)



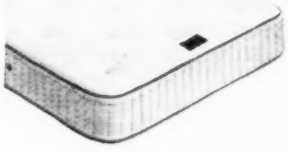
Here's another Beautyrest exclusive—★★★Three Star Crushproof Border. Note the extra heavy upholstery—the coils attached to the border before it's sewn to the mattress. That means the edge will last as long as the center—side sag won't ruin this mattress before its time. (Gives greater patient safety, too—with midmattress support right out to edge. Greater ease in getting in and out of bed—less danger of falling out of bed.)



Gatch type beds can torture hospital mattresses. But Beautyrest *independently* acting coils provide better flexing with less internal strain than ordinary wired-together coil spring mattresses. With Beautyrest, each spring responds to pressure *without transmitting stress to others.* Each is encased in a separate pocket of sturdy muslin which prevents intermeshing of coils when mattress is bent.



Tested and proved the hard way! After 400,000 single passes by this U. S. Testing Co. torture machine (equal to years and years of hard service) a Beautyrest mattress showed *no broken coils, no coil compression set, fabric still in good condition!* Month after month in exhaustive comparison tests, Beautyrest mattresses last *far longer* than any mattress tested.



Beautyrest for hospitals. Made only by Simmons.

Best for Your Budget, too!

Beautyrest is the best buy for *any* hospital budget. It is designed to meet every demand of heavy duty service . . . to last years longer. Whether you need only a few mattresses for replacements, or a full complement for a large new hospital, it will pay in the long run to choose Beautyrest. See your hospital supply dealer for full information or, write

SIMMONS COMPANY
HOSPITAL DIVISION

Display Rooms:
Chicago 54, Merchandise Mart • New York 16, One Park Ave.
San Francisco 11, 295 Bay St. • Atlanta 1, 353 Jones Ave., N.W.

IS YOUR HOSPITAL "SPROUTING WINGS?"

If so . . . there's a Barnstead Water Still "Made to Order" for it!

THE GROWING HOSPITAL needs plenty of pure, freshly-distilled water to meet its expanding requirements. Whether its a tiny ½ gallon per hour laboratory still, or a 30 gallon per hour steam model, such as the one shown at the right, Barnstead makes a model which will exactly fit your needs. These are models for operation by steam, gas, electricity, and kerosene, in a wide range of capacities. Our special catalog of Hospital Stills gives complete data on stills, full automatic controls, storage tanks, recessed equipment, etc. Write for your copy today.

Pure Water Specialists Since 1878

Barnstead
STILL & STERILIZER CO.

31 Lanesville Terrace, Forest Hills, Boston 31, Mass.

Why the Barnstead Type "Q" Still is the Hospital Favorite . . .

DOCTORS LIKE IT *because*

. . . they know it delivers the highest purity water possible with a single effect still, safe even for parenteral solutions and blood plasma work.

NURSES LIKE IT *because*

. . . they know they can rely upon the constant unvarying quality of the distillate. When operated with reasonable care, there is never the slightest variation.

TECHNICIANS LIKE IT *because*

. . . of its trouble-free operation. Barnstead Stills are automatic in operation — it is merely necessary to turn on the water supply and the heat.

ATTENDANTS LIKE IT *because*

. . . its scientifically correct design reduces the need for cleaning. Barnstead Stills operate for long periods without requiring cleaning — even in hard-water areas.

THIS "SKIN SPECIALIST" HAS HAD 70 YEARS OF EXPERIENCE

Cleansing the skin thoroughly and gently has been Ivory Soap's main job for the past 70 years. And that period of service, you'll agree, should be qualification enough for *any* "specialist."

Throughout its 70 years, Ivory has served in countless American hospitals. Logically so, for hospitals were quick to appreciate that Ivory—because of its exceptional purity and gentleness—could contribute something very worthwhile to patient comfort.

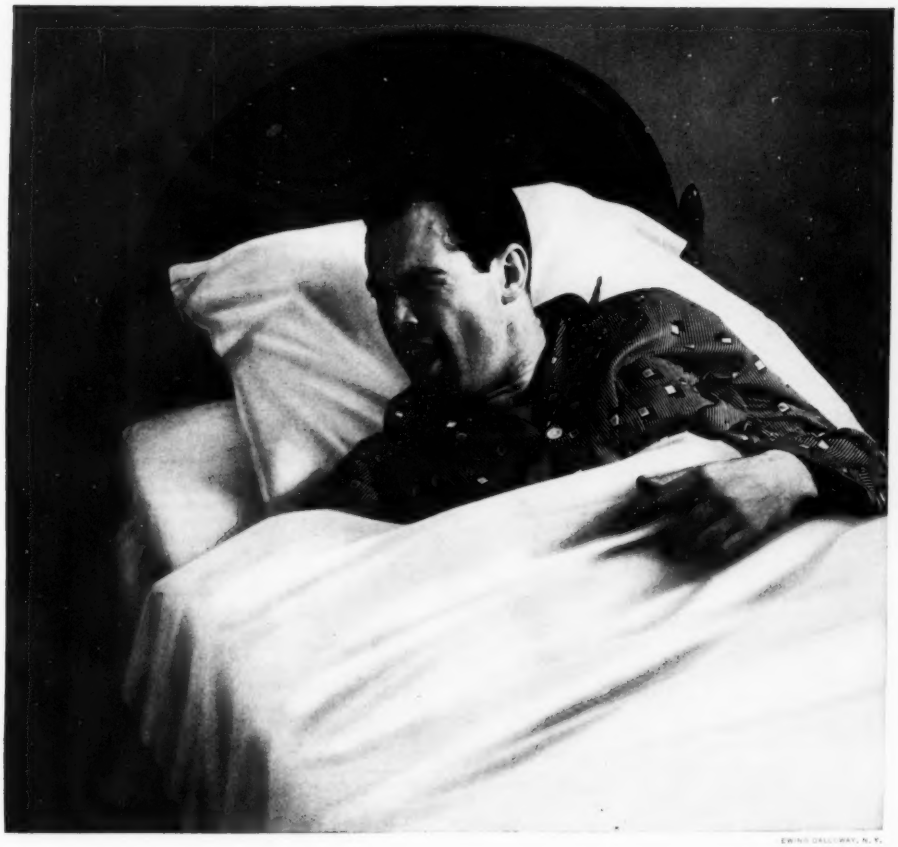
This experienced "skin specialist" is well qualified to serve *your* institution.
Call him in—soon.

99 44/100% *pure*
it floats

Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes, wrapped or unwrapped. Today's Ivory is finer than ever—richer lathering, handsomer, easier to handle.

Procter & Gamble

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!



Know rest FOR THE WEARY!

Get to know Pacific Balanced Sheets. Their wearing ability and rich softness make life easy for you and those who have to take their ease. Perfect balance does it! Pacific gives these famous muslins all the luxury and strength possible without sacrificing one bit of either quality.

Easy-on-your-budget Pacific Balanced Sheets give more for your money — so get in touch with your wholesaler today.

BALANCED **PACIFIC** SHEETS

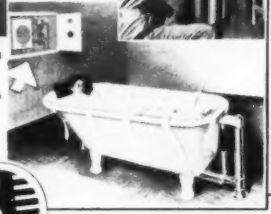
PACIFIC MILLS 214 CHURCH STREET, NEW YORK 13, N. Y.

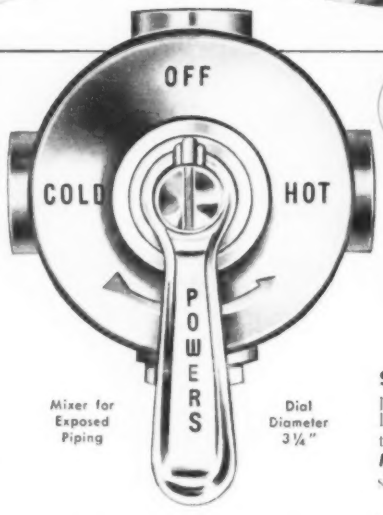
Powers Type H Thermostatic Supply S-4629—for various hospital baths, X-Ray film developing, etc. Only one of many different types of fixtures shown in our HOSPITAL catalog. May we send you a copy?

Extreme accuracy make POWERS Type H mixers ideal for hydrotherapy and other baths.

Photos above: Leg and arm baths.

At right: Continuous flow bath.





Mixer for Exposed Piping

Dial Diameter 3¼"

Only One Moving Part

POWERS Type H

Thermostatic WATER MIXERS

are SAFE against scalding caused by

1 PRESSURE *or* 2 TEMPERATURE

fluctuations in water supply lines

Safer—because of their quick acting response to any change in temperature setting, pressure or temperature variations in water supply lines. Users report control within ½°F. **Greater Comfort**—shower temperature remains constant wherever set. No jumpy temperatures. **More Economical**—POWERS thermostatic mixers promptly deliver showers at the right temperature ..no waste of time, hot or cold water.

For new installations or when modernizing obsolete showers . . . play safe, use Powers type H thermostatic shower mixers. May we send Circular H-18? **CHICAGO 14, ILL., 2720 Greenview Ave. • NEW YORK 17, N. Y., 231 E. 46th St. LOS ANGELES 5, CAL., 1808 W. Eighth St. • TORONTO, ONT., 195 Spadina Ave.**

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Over 55 Years of Water Temperature Control

HMH

WANT ADVERTISEMENTS

POSITIONS WANTED

ACCOUNTANT—Experienced; college degree; controller or business manager; small hospital or clinic in midwest; married man; middle aged. MW 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Assistant; age 30 years; 6½ years hospital experience including accounting, business management, purchasing, personnel relations, credits and collections; to sum up, general administrative assistant work covering both business and professional phases; 6 years' public accounting and auditing experience. MW 43, The Modern Hospital, 919 N. Michigan Avenue, Chicago, Ill.

ADMINISTRATOR—Or assistant; three years experience college business manager and accountant; know cost apportioning; college graduate B.A., M.A., Business Administration; wife active R.N. MW 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—R.N. seeks appointment in 100-bed hospital; 8 years operating room supervisor; 6 years assistant superintendent; 3½ years administrator; available 60 days. MW 36, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Single, protestant; B.S., M.A. in Nursing Education and Administration, experience in administration of nursing schools and nursing services. MW 33, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PURCHASING AGENT-BUSINESS MANAGER—20 years with large eastern hospital; inventory control; personnel director, seeks position, eastern or midwestern institution. MW 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR — B.A. Degree; member ACHA; courses in administration, University of Chicago; 15 years, superintendent 70-bed mid-western hospital; present position 4 years; new addition constructed.

ADMINISTRATOR—Age, 39 years; 5 years MAC; 1 year director, state hospital survey, south; 3 years administrator, 150-bed hospital; prefers southern location.

ASSISTANT DIRECTOR—Master's degree, Hospital Administration, Columbia University; accounting background; 1 year's administrative internship; 2 years assistant director.

RECORD LIBRARIAN—Registered; age, 35 years; 7 years chief librarian, 300-bed hospital.

DIRECTOR OF NURSES—B.S. Degree; graduate Pennsylvania hospital; 6 years night supervisor, and assistant director; 5 years director of nurses, 200-bed New England hospital.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR Lay; A.B. degree, eastern university; six years' administrative experience in field of education; eleven years' education, one of leading hospitals in east; FACHA.

ADMINISTRATOR—Medical; degrees from leading schools; four years, assistant administrator, university group; seven years, administrator, 400-bed hospital; FACHA.

ADMINISTRATOR—Assistantship or directorship; small hospital; M.S., Hospital Administration year's administrative internship and year's assistantship, teaching hospital.

ADMINISTRATOR—Graduate nurse; Master's in Hospital Administration; in thirties; prefers small hospital or assistantship, large hospital.

ANESTHESIOLOGIST—Diplomate, American Board of Anesthesiology; several years' private practice of anesthesiology; prefers directorship, hospital department.

DIRECTOR OF NURSES—Preferably in collegiate school; B.S., M.A. degrees, eastern schools; interesting record of executive experience including that as dean in university school.

ORAL SURGEON—three-year fellowship, oral surgery; Master's degree, oral surgery.

PATHOLOGIST—Diplomate, recognized nationally as one of leaders in pathology; now chief, department pathology, teaching hospital; in early forties.

RADIOLOGIST—Diplomate, American Board; four years, assistant radiologist, large teaching hospital; seven years, director, radiology, 250-bed hospital.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Ave.
Chicago 1, Illinois

ROENTGENOLOGIST — Age 34, English, Protestant, expects certification June 1949; two years residency in roentgenology, excellent midwestern hospital; has degree of Master of Science in Surgery, June 1947; nice personality; available, July 1; write for complete biography.

ADMINISTRATOR Age 31, English, Protestant, with M.S. Degree and B.S. in Business Administration; at present completing one year hospital administrative internship excellent midwestern hospital; desires assistantship in large hospital or administration of smaller hospital; highly recommended; available, June 1.

PATHOLOGIST—Age 33, Norwegian, Lutheran; three years preparation in pathology; lacks 14 months credit toward certification; seeks position as pathologist or director of laboratories; will consider assistantship; available, July 1; asking $8,000.

(Continued on page 218)

POSITIONS OPEN

ADMINISTRATOR—For 80-bed hospital; under construction in northern New Jersey; member of ACHA; experienced in all phases of management, including equipment and personnel. MO 41, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Large psychiatric operation; east; 40-55 years; must be top-flight executive psychiatrist with outstanding organization and management ability; salary in five figures; submit full information as to professional and management background; all replies held in strict confidence. MO 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—For 80-bed general hospital approved by ACS; two anesthetists employed; salary open; new nurses' home. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

ANESTHETIST—For 160-bed hospital employing graduate staff; three anesthetists employed; salary open; comfortable and attractive nurses' residence; central Wisconsin city of 30,000. Apply, Administrator, Wausau Memorial Hospital, Wausau, Wisconsin.

ANESTHETIST—Nurse Anesthetist; to join staff of 460 bed hospital; 44-hour week; pension plan; excellent living accommodations. Apply, Administrator, The Reading Hospital, Reading, Pennsylvania.

ANESTHETIST—Graduate nurse; in a modern, well-equipped, 200-bed Michigan hospital; located in lake area in close proximity to metropolitan Detroit; five anesthetists on staff; $275 base pay with $10 step increases at 6, 12, 24 and 36 months; excellent cafeteria meals; uniforms laundered. Write, Director, Pontiac General Hospital, Pontiac, Michigan.

ANESTHETISTS—Nurse; two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; five-day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

ANESTHETIST—Two; needed at once, for a 75-bed approved hospital; $300 per month, maintenance. MO 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN — Administrative; Pontiac General Hospital, Pontiac, Michigan; full charge staff of forty with good non-professional supervisory assistance; modern 190-bed plant, up to date kitchen equipment; candidates should have education and training equivalent to graduation from college with major in dietetics; previous supervisory experience is desirable; salary $3,440-3,840 per year, with annual increments of $120; two increases in first year; maintenance available at nominal charges; city owned hospital; civil service, retirement system, liberal sick leave and vacation; educational and cultural advantages in Detroit one hour away by public transportation. Apply, Personnel Director, Pontiac General Hospital, Pontiac 18, Michigan.

WANT ADVERTISEMENTS

POSITIONS OPEN

DIETITIAN—Position open in July, for an accredited dietitian; to manage pay cafeteria for hospital employees in 150-bed general hospital in college town; central Connecticut. For details, write, MO 40, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Executive; to assume charge of department in 340-bed general hospital; must be ADA member in good standing; experience as assistant preferred; interview required; salary liberal and open; full maintenance furnished. Apply, Superintendent, Norfolk General Hospital, Norfolk 7, Virginia.

DIETITIAN—Member of ADA; to have full charge of dietary department; 100-bed general hospital; salary open. Apply, Superintendent, St. Mary's Hospital, Cairo, Illinois.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Registered, capable and efficient; for a high class 100-bed general hospital, with graduate nursing service, and well organized medical staff; attractive and pleasant environment; salary open. If interested, address Director, John D. Archbold Memorial Hospital, Thomasville, Georgia. An investigation may prove mutually helpful. Write today.

DIETITIAN—Therapeutic; member of ADA; 136-bed hospital affiliated with large medical center; salary open. Apply to Miss Estelle D. Claiborne, Administrator, St. Louis Children's Hospital, St. Louis 10, Missouri.

DIRECTOR OF NURSES—Assistant; splendid opportunity in 425-bed fully approved general hospital in Portland, Maine; Portland is a beautiful seacoast city with many lakes nearby; two hours from Boston by train; hospital has accredited school; applicant must have degree with several years' experience; salary open. Apply, Director of Nurses, Maine General Hospital, Portland 4, Maine.

DIRECTOR OF NURSES—250-bed; fully approved hospital in Great Falls, Montana; 125 miles to Glacier Park and 175 miles to Yellowstone Park; hospital has accredited school; applicant must have degree with experience; salary open. Apply to administrator, Montana Deaconess Hospital, Great Falls, Montana.

DIRECTOR OF NURSES—Bachelor's degree required; Masters Degree desirable; three years psychiatric nursing experience, five years supervisory or administrative experience; New Jersey civil service; salary range $4200.00 to $5100.00 per annum; attractive living quarters. Address, Personnel Office, New Jersey State Hospital, Marlboro, New Jersey.

DIRECTOR OF NURSING EDUCATION—Qualified to arrange program and teach basic sciences; 233-bed hospital in Massachusetts; accredited school of nursing; salaries open. Apply, MO 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 220)

INSTRUCTOR—Clinical; with baccalaureate degree and post graduate course in pediatric nursing. Mount Carmel Mercy Hospital School of Nursing, Unit of Mercy College, 6131 West Outer Drive, Detroit 21, Michigan.

INSTRUCTOR—For small training school at once; maintenance provided; apply, stating qualifications and salary expected, Superintendent, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

INSTRUCTORS—Nursing arts and science instructor, for fall term; 138-bed hospital; 60 student nurses. Apply, stating qualifications, to Superintendent of Nurses, General Hospital, Yorkton, Saskatchewan.

INSTRUCTOR—Science; excellent opportunity; for approved school of nursing; 400-bed general hospital; special employee benefits. For details, apply Personnel Director, The Christ Hospital, Cincinnati, Ohio.

INSTRUCTOR—Science; with degree for accredited school of nursing; average enrollment 50 students; salary based on background and experience; liberal personnel policies including bonus plan. Please communicate with Director of Nurses, The Holzer Hospital, Gallipolis, Ohio.

LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

WANT ADVERTISEMENTS

POSITIONS OPEN

INTERSTATE—*Continued*

MISCELLANEOUS — Assistant Director of Nursing Service; Nursing Arts Insructors; Surgical and Medical Nursing Instructors; Degree and experience preferred; 500-bed general hospital with school of nursing; 40 hour week; salary open. Apply, Director of School and Nursing Service, Sacred Heart Hospital, Spokane, Washington.

MISCELLANEOUS — Clinical instructor and operating room supervisor; for modern, well-equipped 323-bed hospital; school of nursing three-year and five-year programs; salary based on background and experience. Apply, Principal, School of Nursing, Eastern Maine General Hospital, Bangor, Maine.

MISCELLANEOUS — Laboratory and X-Ray Technician, combination, Anesthetist, Registered Nurses; salary good with complete maintenance. MO 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS—Nursing arts instructor; Science instructor; Experienced teaching surgical supervisor; First assistant to dietitian-in-charge; positions open immediately; salary for each opening, $180 gross per month; one month holiday with pay; 6 statutory holidays. Apply, stating qualifications, to Director of Nursing or Principal of Nursing Education or Dietitian-in-Charge, General Hospital, Kingston, Ontario.

MISCELLANEOUS—Positions open, now; in new and remodeled 50-bed hospital; day and night supervisors, surgical nurse, general staff and graduate practical nurses; excellent personnel practices and salaries. Apply, Director of Nursing, Eben-Ezer Hospital, Brush, Colorado.

MISCELLANEOUS—Registered nurses (2) for general duty; 50-bed hospital; 8-hour duty, 6-day week; salary, $110 day duty; $115 night duty; $120 evening duty; full maintenance; attractive nurses' residence; 22 miles from Lake Huron; also Assistant Superintendent. Apply, Scott Memorial Hospital, Seaforth, Ontario.

MISCELLANEOUS—Staff nurses; beginning salary $165.00 per month with full maintenance; raises at six months and year; Supervisor, also wanted; for hours 3 to 11; salary according to experience. Write, Wabash County Hospital, Wabash, Indiana.

MISCELLANEOUS—Staff Nurses and Supervisors; unique opportunities in progressive program for psychiatric patients; modern nurses' home; many recreational facilities; excellent educational program; promotional opportunities; automatic increases; maintenance optional; liberal vacation and illness policies; hospital and group insurance; 8-hour day, no split shifts; 11 holidays; graduate nurse $2,340-$2,700; head nurse $2,580-$2,940; supervisor $2,820-$3,420. Apply, Director of Nursing, Norwich State Hospital, Norwich, Connecticut.

(Continued on page 222)

MISCELLANEOUS—Superintendent of Nurses; middle age; several years of experience; competent to manage 50-bed hospital; Nurse Anesthetist; who may also assist operating room supervisor; liberal salaries and complete maintenance. Coker's Hospital, Canton, Georgia.

NURSE—Graduate for supervisory position in 200-bed private hospital, treating all types of mental patients; one hour from New York city; salary $215 to $235 according to experience, with maintenance available at cost of $35 per month; 5-day, 40-hour, 4 week vacation, 10 day sick leave. South Oaks, Box 467, Amityville, L. I., New York.

NURSE—Operating room; with some general experience in operating room; good opportunity in small hospital. Apply, Mahaska Hospital, Oskaloosa, Iowa.

NURSES—General duty; for full particulars write, Josephine Hunlock, R.N., Superintendent of Nurses, Greene County Hospital, Jefferson, Iowa.

NURSES—General duty; 16-bed modern hospital in heart of the Rocky Mountains; $175.00, 7-3; $185.00, 3-11; two meals; laundry; sick leave; vacation, 14 work days; full information if interested. Apply, Solandt Memorial Hospital, Hayden, Colorado.

WANT ADVERTISEMENTS

POSITIONS OPEN

NURSES—General staff; for 150-bed hospital in an industrial city along lake Michigan in America's dairyland; good transportation to either Chicago or Milwaukee; eligible for Wisconsin registration; salary $200 per month; additional for 3-11 and 11-7 shifts; 42 hour week. Apply, Director of Nurses, Kenosha Hospital, Kenosha, Wisconsin.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate; for 475-bed hospital; salary open. Apply, St. Barnabas Hospital for Chronic Diseases, 183rd Street & 3rd Avenue, New York 57, New York.

NURSES—Obstetrical; California hospital on San Francisco Bay; forty minutes from that city; five-day week; salary $225.00 per month if post graduate or experienced; $10.00 additional for evening and night hours; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room; to scrub for surgery; 44-hour week; salary from $180 to $215 per month, depending upon experience; full or partial maintenance provided at a nominal fee; opportunities for advancement; two weeks' vacation yearly; sick time allowance. Apply Director of Nursing, Bridgeport Hospital, Bridgeport, Connecticut.

NURSES—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

NURSES—Staff; for operating room and obstetrical department; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

NURSES—Staff; for 465-bed general hospital; rotating shift or permanent 3-11 or 11-7 shifts available; on days, salary is $200 per month; on evenings and nights, $225 per month; increments offered at six month intervals for 3 years. Apply, Director, School of Nursing, Miami Valley Hospital, Dayton, Ohio.

NURSES—Staff; eligible for registration in Michigan, U.S.A.; needed for all services in modern 200-bed hospital; salary $216 per month for 44-hr. wk. 6-month increase, $10 extra for 3-11 & 11-7 duty; 7 legal holidays; 12 vacation & 10 days sick leave per year; cafeteria meal service; laundry furnished; room available at $10 per month. Apply, Director of Nurses, General Hospital, Pontiac, Michigan.

NURSES—Staff; California hospital on San Francisco Bay; forty minutes from that city; all departments; five day week; salary $215.00 per month; $10.00 additional evenings and nights; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

OCCUPATIONAL THERAPIST—Director of occupational therapy in 900-bed medical center hospital in midwest; qualified to direct department, other therapists and clinical training program. Write, MO 42, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

OCCUPATIONAL THERAPISTS—Graduate, registered; trained recreation workers for assignment in Illinois state psychiatric hospitals; schools for mental defectives; children's and correctional institutions; civil service positions; career service with opportunity for advancement; good salaries; excellent retirement and insurance plan; maintenance available if desired. Applicants may contact Miss Bertha E. Schlotter, Room 1500, 160 N. LaSalle Street, Chicago 1, Illinois.

RESIDENCIES IN PSYCHIATRY Two; salary $3650 first year; $4150 second year; graduate approved school; 1 year's internship; eligible for New York license. Address, Dr. E. H. Mudge, Gowanda State Hospital, Helmuth, New York.

(Continued on page 224)

WANT ADVERTISEMENTS

POSITIONS OPEN

RESIDENTS—Desirable openings in all services; attractive 200-bed hospital; good salary with complete maintenance. Apply, Director, Doctors Hospital of the Cleveland Memorial Medical Foundation, 12345 Cedar Road, Cleveland Heights 6, Ohio.

RESIDENTS—Immediately; Pennsylvania license required; excellent for experience on all services of a general hospital; 102 beds; active out-patient department; salary attractive and full maintenance provided. Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

SUPERVISOR—Night; for 50-bed maternity hospital. Apply, stating qualifications, salary, etc., to Superintendent, Catherine Booth Mothers' Hospital, 4400 Walkley Avenue, Montreal 28, Quebec, Canada.

SUPERVISOR—Night; 11-7 shift; graduate staff employed; average 100-120 patients; good salary to right person. Wausau Memorial Hospital, Wausau, Wisconsin.

SUPERVISOR OF NURSES—Assistant; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

SUPERINTENDENT OF NURSES—Pontiac General Hospital, Pontiac, Michigan. Opportunity to reorganize and improve nursing service as recommended by recent professional survey; applicants should be aggressive and adaptable, have wide background and considerable administrative experience in nursing, and education equivalent to college graduation with courses in nursing administration; salary $3780-$4680 with annual increments of $180; two increases in first year; maintenance available at nominal charges; modern 190-bed plant, large intern-resident program, excellent supporting services, single director; municipal retirement system, liberal sick leave and vacation, tenure under city merit system; educational and cultural opportunities in Detroit one hour away by public transportation. Application blanks furnished on request to Personnel Director, Pontiac General Hospital, Pontiac 18, Michigan.

TECHNOLOGIST—Laboratory; in modern 75-bed hospital with large out-patient department; four full time technologists employed; hospital is approved by American College of Surgeons and has state approved laboratory; expansion contemplated; liberal personnel policy with bonus plan. Communicate with Dr. Charles E. Holzer, Superintendent, The Holzer Hospital, Gallipolis, Ohio.

TECHNICIAN—Medical laboratory; registration preferred; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

TECHNOLOGIST—Medical; registered; to work in general laboratory of community blood center; experience in blood bank work not required. Apply, T. J. Greenwalt, Medical Director, Junior League Blood Center of Milwaukee, 925 West Wells Street, Milwaukee 3, Wisconsin.

TECHNOLOGIST—Registered medical; for 252-bed modern hospital; 40-hour week; $225 per month. Apply, Superior, Columbus Hospital, Great Falls, Montana.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ANAESTHETISTS—(a) $325, maintenance; midwest. (b) University hospital; central states; $300.

SUPERINTENDENTS—(a) 110-bed hospital; western New York; 50-bed addition planned. (b) 90-bed hospital now under construction; suburb, New York. (c) 40-bed hospital, Ohio; 30-bed annex being opened soon. (d) 150-bed new hospital, Florida.

ADMINISTRATORS—(a) 225-bed hospital, Ohio. (b) Assistant; 500-bed Pennsylvania hospital.

DIRECTORS OF NURSES—(a) Large psychiatric hospital, east. (b) 320-bed children's hospital; $4500. (c) 400-bed university hospital, south.

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WANT ADVERTISEMENTS

POSITIONS OPEN

INTERSTATE—*Continued*

DIRECTORS OF NURSING (a) 250-bed hospital, eastern college town; $4200, maintenance. (b) 200-bed hospital, New England; school accredited by NLNE. (c) 250-bed Pennsylvania hospital. (d) 225-bed hospital, Ohio.

EDUCATIONAL DIRECTORS—(a) 400-bed hospital, mid-western city; $4,000. (b) Sisters' hospital, Ohio; school accredited, NLNE; $325, maintenance. (c) 275-bed New Jersey hospital.

INSTRUCTORS (a) Science; $225-$250. (b) Nursing arts; $225-$275, maintenance. (c) Clinical, medical, surgical, tuberculosis, contagion, obstetrical, operating room; attractive opportunities; open June-August.

TECHNICIANS—(a) Chief laboratory, Ohio; $300. (b) X-ray; $200, maintenance. (c) Physiotherapists; $225, maintenance. (d) Pharmacists; Michigan, Ohio, New Jersey.

EXECUTIVE HOUSEKEEPERS (a) 325-bed general hospital, east. (b) 100-bed hospital, Ohio.

DIETITIANS (a) Administrative; 300-bed hospital, near Philadelphia, Pennsylvania. (b) Dietitians, therapeutic; 350-bed hospital, Ohio. (c) 100-bed hospital, Illinois; $275, maintenance.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS (a) Voluntary hospital, 300-beds; building program will increase to 500; medical director preferred, lay administrator eligible; east. (b) Tuberculosis hospital now under construction; Pacific coast. (c) Lay; private hospital; present patient average 225; contemplated building program will increase to nearly 500; Chicago area. (d) Lay; five and half million hospital now being completed under American auspices in South America; should be formally trained in Hospital Administration, qualified to speak Spanish fluently. (e) Medical; 450-bed teaching hospital; university medical center. (f) General hospital now under construction; preferably someone experienced in building, equipping, recruiting personnel; east. (g) General hospital; patient average 160; plans for new hospital, 200-beds; Canada. (h) Assistant medical director; physician interested career hospital administration required; university hospital. (i) General hospital; 100 beds affiliated with 10-man group; southwest. MH5-1

ADMINISTRATORS-NURSES — (a) General voluntary hospital; 110-beds; expansion program; town of 30,000, short distance from university center. (b) General hospital of small size now under construction; thriving Texas town, short distances from several large cities. (c) Small sanatorium for pulmonary tuberculosis; small town located in summer resort area of east. MH5-2

(Continued on page 228)

MEDICAL BUREAU—*Continued*

ANESTHETISTS (a) Small general hospital operated by American company in Venezuela; knowledge of Spanish desirable. (b) Large general hospital; town of 125,000 located in beautiful section of eastern state; new dormitory providing private room or apartment; $350. (c) New hospital, 140-beds; no anesthetics for obstetrical department; town of 10,000, short distance from university city; Pacific northwest; $350-375. MH5-3

DIRECTORS OF NURSES (a) One of the most important appointments in profession; nationally known hospital having teaching affiliations; associate directors in charge of school and nursing service; $7200, maintenance. (b) Fairly large hospital considered one of the most important in California. (c) Pediatric unit of university group; school of eighty students; outstanding candidate required; $6000. (d) New hospital in South America operated under American auspices; no school; knowledge of Spanish required; minimum $6000. (e) 500-bed hospital; medical school affiliation; collegiate programs; university medical center; east; $5000-$6000. (f) General hospital under construction; 80-beds; all graduate staff; $4200, maintenance; middle west. (g) Voluntary hospital 500-beds; 300 students; educational center; $5000-$6000. (h) State university; newly created appointment; duties include surveying schools, administering scholarship program; $5000. MH5-5

WANT ADVERTISEMENTS

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIETITIANS AND NUTRITIONISTS (a) Administrative dietitian; general hospital, 250-bed hospital, university center; $5000; east. (b) Department of metabolism therapy; group clinic; excellent opportunity for specialized training in diet consulting work. (c) Nutritionist; duties serving as consultant for pediatric and obstetrical patients; university appointment; middle west. (d) Assistant nutrition advisor; large industrial company; east. (e) Nutrition consultant; public health appointment outside Continental United States; $4800-$6000. (f) Assistant dietitian; fairly large hospital; southern California. MH5-4

EXECUTIVE SECRETARIES (a) District nurses' association; membership more than 700; middle west. (b) New organization serving hospital field; public relations training desirable; $4000. MH5-6

FACULTY APPOINTMENTS (a) Educational director; collegiate school of nursing recently established by one of the country's oldest liberal arts colleges; capable organizer required. (b) Psychiatric instructor; psychiatric unit of modern, well equipped hospital; $400, complete maintenance; outside Continental United States. (c) Nursing arts instructor; university school; four-year course; quarters available on campus; university medical center; $3900. (d) Science instructor; university hospital; active faculty organization; well staffed department; $3880-$4100.

MEDICAL BUREAU—*Continued*

(e) Director to establish and conduct program for practical nurses; minimum $4000; middle west. (f) Assistant in nursing education; one of Hawaii's leading hospitals. (g) Science small general hospital; eighty students; capital of United States dependency. (h) Educational director; 350-bed general hospital; college town of 40,000, southeast; $300, maintenance. MH5-7

MALE REGISTERED NURSES (a) Several; general hospital; 300 beds; town, 45,000 short distance from university center; east. (b) Trained in anesthesiology; small hospital; middle west; $4200. MH5-8

MISCELLANEOUS (a) Public health nurse to direct generalized program including school health; $3500-$5000. (b) Director school health program; public schools; middle west. (c) College nurse; liberal arts college; university center. (d) Director, nurses' residence; training in personnel guidance desirable; university hospital. MH5-9

MEDICAL RECORD LIBRARIANS (a) Chief; 500-bed hospital; town, 150,000 near university center; $3000, complete maintenance; east. (b) Small general hospital; Pacific northwest; minimum $3000. (c) Chief; standard nomenclature; 350-bed hospital; attractive city, southeast, short distance from ocean. (d) Chief; large teaching hospital; staff of 32; much sought-after location. MH5-10

PHARMACIST (a) Capable of organizing and managing pharmacy serving three teaching hospital units; duties include charge of solutions room; $4800. MH5-11

(*Continued on page 230*)

MEDICAL BUREAU—*Continued*

STAFF NURSES (a) Surgical; new hospital; Hawaii. (b) Several staff; 200-bed general hospital; Pacific northwest; $3380. (c) Several and, also supervisors, new hospital; Alaska. MH5-12

SUPERVISORS (a) Operating room; qualified to reorganize department; fairly large hospital; modern, beautiful new nurses' home; minimum $260; southern California. (b) Pediatric; fairly active service; 30-bed department; 200-bed hospital fashionable summer resort town; New England. (c) Obstetrical; hospital of medium size; vicinity New York City; $3000, partial maintenance. (d) Floor; small general hospital, college town in Pacific northwest; $225 maintenance. (e) Night; small general hospital; town of 40,000, summer resort area of Wisconsin; $250, maintenance. MH5-13

MEDICAL PERSONNEL EXCHANGE

Formerly

Nurses' Exchange and Placement Service
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Penna.

ANESTHETIST 240-bed, Ohio; $250, maintenance.

DIRECTOR OF NURSING 150-bed, Pennsylvania; $4000; maintenance includes apartment.

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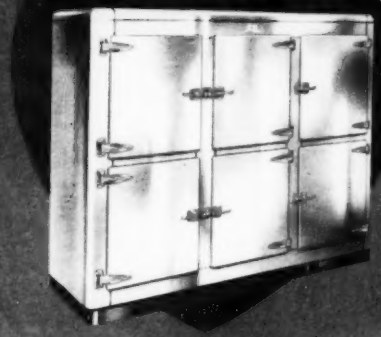
REFRIGERATORS

"HEART" OF YOUR KITCHEN



COMPLETE FOOD CONDITIONING

Install HERRICK "plus-refrigerators" as the center of all your kitchen activities. You'll be pleased by the way these units increase the efficiency of your kitchen personnel.

With HERRICK refrigerators you'll enjoy, too, the many advantages of *complete food conditioning* . . . the perfect balance of uniform temperature, correct humidity and positive yet gentle circulation. This important "plus-feature" prevents food spoilage . . . means added savings for you. Write for the name of your nearest supplier.

See us at Booth 210, Nat'l. Restaurant Convention and Exposition, Atlantic City, May 24-27.

HERRICK THE "PLUS+ REFRIGERATOR"
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STAINLESS STEEL
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The Aristocrat of Refrigerators

Speed up Food Preparation from Soup to Nuts . .

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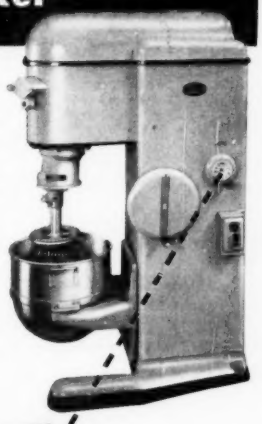
BLAKESLEE

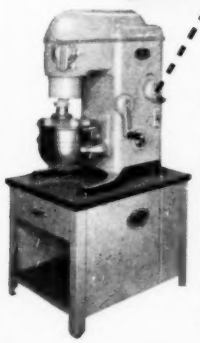
Vertical Mixer

All Blakeslee-Built Mixers are equipped with an auxiliary drive from which attachments such as Food and Meat Chopper, Vegetable Slicer, Juice Extractor and many other time and money saving attachments may be operated. Here is real-help in the preparation of food for your entire menu.



Available in a Duco Finish or gleaming Stainless-Clad Construction.

***Any Speed* at the turn of a dial!**



Blakeslee Mixers are available in sizes from 12 quart to 80 quart capacities. The smaller models are furnished as either floor models or bench models. Where floor space is available, floor models are definitely recommended as they conserve valuable bench space. Furthermore, most benches are not built to stand the weight and vibrations of a heavy mixer. Blakeslee Mixers provide any speed (not just 3 or 4). Speeds are changed without stopping the beater which saves wear and tear of continually starting and stopping.

Write for complete information.

Since 1880 BLAKESLEE BUILT KITCHEN MACHINES

BLAKESLEE

DISHWASHERS • PEELERS • MIXERS

G. S. BLAKESLEE & CO., Main Office: CICERO STA., CHICAGO 50
NEW YORK, N. Y. TORONTO, ONT.

WANT ADVERTISEMENTS

POSITIONS OPEN

MEDICAL PERSONNEL EXCHANGE
—Continued

DIETITIAN Head; 400-bed, Virginia; to $3300; maintenance.

EDUCATIONAL DIRECTOR—Group of hospitals; starting, $3500; 5 day week; 2 months summer vacation and all holidays.

INSTRUCTORS (a) Science. (b) Nursing arts; $3200, for 10 months 5 day week.

SUPERVISOR Operating room, New England; $250, maintenance.

TECHNICIAN Laboratory, Ohio; $250, maintenance.

PHARMACIST Chief, male or female; starting, $300.

RECORD LIBRARIANS (a) Delaware; $250, maintenance. (b) Pennsylvania; $275.

PATHOLOGIST — 100-bed, New England; $10,000.

PSYCHIATRIST—Large school, New York; attractive salary.

MISCELLANEOUS (a) Director of nursing, Puerto Rico; $3200, maintenance; excellent living conditions. (b) Staff nurse, Alaska; $200, maintenance.

WE MAKE NO CHARGE FOR REGISTRATION

MEDICAL PLACEMENT AND MAILING SERVICE

Mrs. Stewart Roberts
768 Juniper Street, North East
Atlanta, Ga.

ANESTHETISTS (a) Nebraska hospital; salary open. (b) Nurse anesthetist; Georgia hospital; salary and maintenance. (c) Virginia hospital; salary open. (d) Georgia hospital; $250.00 and maintenance.

DIETITIANS (a) 70-bed hospital; Virginia; Salary $175.00 plus full maintenance. (b) 75-bed Maryland hospital; reasonable salary.

LABORATORY TECHNICIANS (a) North Carolina; registered technician qualified to teach. (b) Maryland hospital; x-ray and laboratory technician. (c) Florida; office technician. (d) South Carolina and Mississippi hospitals have laboratory openings.

NURSES (a) Operating room nurse; Georgia hospital; $165.00 and maintenance (b) General duty nurses; Georgia and Alabama hospitals.

ADMINISTRATORS (a) Texas hospital; salary open. (b) Nurse administrator; Maryland hospital

(Continued on page 232)

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

HOSPITAL SUPERINTENDENT West coast; 100-bed general hospital, fully approved; wonderful opportunity for a man of action with sound ideas of progressive hospital administration.

EDUCATIONAL DIRECTOR—Middle west; 135-bed general hospital; school of nursing accredited and approved; average 50 students; town of 50,000 easily accessible to Chicago.

DIRECTOR OF NURSING Nursing school; east; teaching duties, 1 major subject and 1 minor subject; prefer M.S. degree in administration; 2 months paid vacation; $3600 minimum plus maintenance.

INSTRUCTORS (a) Science; middle west; 145-bed hospital; $3600 plus maintenance. (b) Nursing arts; east; nursing school; 2 months paid vacation; $275 plus maintenance. (c) Social service; Chicago area; 5 day week; 149-bed hospital; $250 plus maintenance.

SUPERVISORS—(a) South; operating room; 285-bed general hospital; $275 plus maintenance. (b) Obstetrical; middle west; 125-bed general hospital; $250 plus maintenance; many others.

ASSISTANT DIRECTOR OF NURSES East; 400 bed hospital; highly rated; large nursing staff; exceptional facilities for all outdoor recreation; $4000 to start.

WANT ADVERTISEMENTS

POSITIONS OPEN

SHAY—*Continued*

ANESTHETIST—Clinic; south; very progressive organization; good opportunity as they plan extensive expansion in the near future; college town, 15,000; ideal climate year around; $400 plus maintenance.

LABORATORY X-RAY TECHNICIAN—Clinic; south; prefer registered but will consider one with good background of experience; good opportunity for someone with administrative ability as they plan to expand in the near future and there will be the need for a person to take complete charge of the laboratory; $3600 to start.

GENERAL DUTY NURSES—Middle west; 30-bed private hospital; 8-hour shifts; $250 plus full maintenance. (b) Pacific coast; 17-bed private hospital; $215 plus full maintenance.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ASSISTANT ADMINISTRATORS—(a) Young; 550-bed eastern hospital having 70 bassinets; also large school of nursing; fully approved; splendid opportunity. (b) 103-bed Michigan hospital; pleasant location.

WOODWARD—*Continued*

ADMINISTRATORS—(a) For 109-bed eastern hospital, having 24 bassinets, planning on enlarging and remodeling soon; college city of 25,000. (b) Preferably man with training and experience in business administration and public relations for 236-bed general hospital; 40 bassinets; salary open; city 50,000. (c) Southern hospital in process of construction; when completed will have 40-beds with possible expansion to 50; county seat town and business center for adjoining area. (d) 50-bed hospital. 12 bassinets; Wyoming, near Yellowstone Park; hospital has complete service, is registered by AMA, has memberships in American Hospital Association and State Hospital Association; salary open.

BUSINESS MANAGER—New privately owned 40-bed hospital, clinic; southwest; salary open.

PLACEMENT BUREAUS

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director
Suite 1004—79 West Monroe Street
Chicago 2, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

(Continued on page 234)

PLACEMENT BUREAUS

L. A. MEDICAL BUREAU (Agency)
756 So. Broadway, Los Angeles 14, Calif.
Telephone Trinity 5618
Harry F. McCafferty, Owner
We invite inquiries from Employers desiring Personnel and from Applicants seeking positions in the Southern California Area.

MEDICAL-DENTAL PERSONNEL BUREAU OF SPOKANE
Mary Lowry, M.T., Director
525 Paulsen Bldg.
Spokane 8, Washington
Many Good Positions in All Medical Specialties in the Great Northwest
Write us for full details.

BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17
If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

WANT ADVERTISEMENTS

MISCELLANEOUS

BOOKBINDING

Have your hospital journals and magazines bound into permanent books. Finest workmanship at reasonable prices. Inquiries invited. NORRIS BOOKBINDING COMPANY, GREENWOOD, MISSISSIPPI.

LINEN CONTROL CONSULTANT
Systems Installed for Hospitals & Institutions
David C. Mullins
825 West 187th St.
New York, 33, N. Y.
Specializing in Systems to
Reduce Linen Costs and Improve Linen Service

FUND RAISING DIRECTOR

Free Lance Fund Raising Director—Available after present campaign ends June 1. Also Public Relations advisor in setting up Hospital P. R. Departments. Write Box MW 37, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SALESMAN wanted, sideline. Only man with good hospital contacts considered. Represent established manufacturer washable service garments. Commission. Write in confidence to A. O. Levin, American Jacket Company, 617 North 8th Street, St. Louis 1, Mo.

MEDICAL AUDITS
HENRY G. FARISH, B.B.A., M.H.A., M.D
Southampton, New York

Formerly Representative, Hospital Standardization Department, American College of Surgeons.

SALESMAN

Manufacturer's Agent—Hospital Purchasing Agent located on west coast with 14 years' experience in hospital supply line, seeks connection with reputable supply house or manufacturer, as representative. Will travel, young, married. Draw against commission basis. Write, MW 42, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

AVAILABLE
Specialist in Hospital
Financial Management

A nationally known authority on hospital business management, organization, accounting and financial controls will be available June 1st for a position as administrator, business manager or comptroller. His experience includes twenty years as comptroller of one of America's largest hospitals and several years as consultant specializing in hospital financial controls. He desires to become associated where his broad experience may be utilized to the fullest extent. Please address inquiries care of Scantlin & Company, 737 North Michigan Avenue, Chicago 11, Illinois.

(Continued on page 236)

FOR SALE

AUTOCLAVES

Stainless Steel, new, Electric, fully automatic, size 16 by 24 inside, $480.00, complete and perfect.

MICROSCOPES

New Monocular Microscopes complete with all Lens, Mechanical Stage, Abbe condensor etc. $195.00.

Send for pictures and details.

HARRY D. WELLS
400 East 59th Street, New York 22, New York

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

FIRE ESCAPES

Spiral or Tubular Slide Type for use in removing bed-ridden patients on mattresses. More than 8000 in use. Catalog on request.

POTTER MANUFACTURING CORP.
6116 N. California Avenue, Chicago 45, Illinois

WANT ADVERTISEMENTS

FOR SALE

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Congress and Honore Streets, Chicago 12, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

HERRICK MEMORIAL HOSPITAL offers the following programs in the Herrick School of Hospital Arts: 12-month course in Anesthesiology for nurses; 12-month course for Medical Record Librarians; 24-month course for x-ray technicians; 12-month course for practical nurses. Courses G.I. approved or approval pending. For further information, apply to the Director, Herrick School of Hospital Arts, 2001 Dwight Way, Berkeley, California.

SCHOOLS—SPECIAL INSTRUCTION

JUNIOR COLLEGE OF PHYSICAL THERAPY, Inc.

Thirty-first Year—1949-1950

Physicians' Course—Short intensive course for graduates in Medicine arranged at any time.

Junior College of Physical Therapy—Two-year course for high school graduates, leading to degree of Associate in Science. Graduates in nursing or physical education and two-year college students admitted to senior year.

Medical Secretary—One-year course for high-school graduates. X-ray and Laboratory—Combined with physical therapy or separately.

For catalog and terms of tuition address: John C. Allen, M.D., President, 262 Bradley St., New Haven 10, Conn.

(Continued on page 238)

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:
Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

Six months' POST-GRADUATE COURSE IN PEDIATRIC NURSING. Classes begin January, April, July, October. Address inquiries to Director of Nursing, Children's Hospital, 1229 W Street, Northwest, Washington 9, D.C.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

QUEEN OF ANGELS HOSPITAL, Los Angeles, California, offers a six-month course for graduate nurses in obstetrics. Classes admitted January 15 and July 15. For further information apply to the Director of Nursing, 2301 Bellevue, Los Angeles 26, California.

TOO LATE TO CLASSIFY

POSITIONS WANTED—*continued*

ADMINISTRATOR—Lay; male; age 45; business administration graduate; personal member American Hospital Association; 20 years' experience in hospital field; at present administrator 160-bed hospital and accredited school of nursing; experienced in building expansion and fund raising; ex-Army officer, World War II, Medical administrative Corps; available, August 15th; highest references. MW 47, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

POSITIONS OPEN—*continued*

THE NEW YORK MEDICAL EXCHANGE
Patricia Edgerly, Director
489 Fifth Avenue
New York, N. Y.

No registration fee.

Stop at Booth 8, Atlantic City, May 18-20.

ADMINISTRATOR—New 80-bed general hospital, New Jersey; planning, purchasing and staffing; salary open.

DIRECTOR OF NURSES—Degree, July 1st; 250-bed general hospital, New Jersey; $4500.

SCIENCE INSTRUCTRESS—Westchester; August 1st; 5 days; $3000.

NURSING ARTS INSTRUCTRESS—Westchester; August 1st; 5 days; $3000.

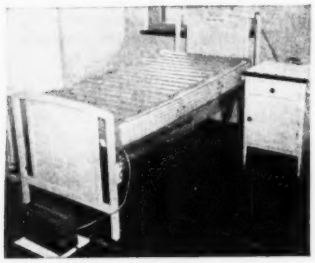
NURSE ANESTHETIST—New Jersey; $290 per month.

DIETITIAN—ADA; rehabilitation hospital school for crippled children; New England; $2400-$3000.

What's New for Hospitals

MAY 1949 — Edited by BESSIE COVERT

Alternating Pressure Mattress



The Alternating Pressure Mattress, described in the November 1948 issue of The Modern Hospital, is now being distributed by the American Sterilizer Company. Designed to reduce or eliminate the possibility of bedsores, especially in patients unable to move or confined to bed for long periods, the new mattress automatically provides continuous redistribution of all pressure points of the patient's body through a system of air cells running transversely the width of the mattress which are alternately inflated and deflated. This prevents the constant pressure otherwise resulting from long bed stay and not only minimizes the possibility of retarding of circulation but produces a slight massaging effect which aids circulation.

The air mattress is made of flexible, waterproof, non-burning plastic which is easily cleaned with soap and water. An air pump driven by a small electric motor accomplishes the alternating inflation and deflation of the air cell systems, five minutes being required for a complete cycle. The operating mechanism is housed in a small metal box measuring 6 by 9 by 14 inches and the motor runs constantly, quietly and requires a minimum of attention. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 614)**

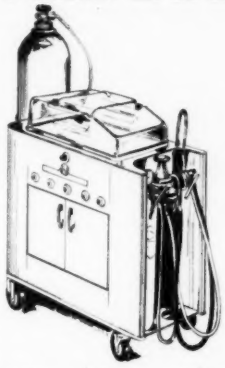
Laboratory Record

A daily summary of laboratory service in the hospital can be kept in a new record book designed for entering daily totals of tests performed. Each book provides for 12 months' service with an extra set of leaves to develop an annual total. **Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 615)**

Resuscitator-Bassinet

The Resucinette is a combination resuscitator-bassinet, designed for emergency delivery room service, which is thermostatically warmed and automatically humidified for reviving the asphyxiated newborn under physiologically correct conditions. Equipped with an E & J resuscitator for applying safe, gentle, positive and negative pressures to encourage a normal respiratory cycle, the unit has an adjustable rest for proper positioning of the infant's head for quick, sure resuscitation and either intratracheal or mask technic may be used.

Safety signals give warnings when there is interference and the machine



can be converted into an aspirator by the turn of a switch. Inhalation of oxygen or other gases is provided for by another control. The durable, stainless steel mobile cabinet and plastic crib are a self-contained unit operating on either AC or DC. **E & J Mfg. Co., Dept. MH, Glendale 1, Calif. (Key No. 616)**

Meat Chopper

The new Biro meat chopper is compact and streamlined in design without projecting or overhanging parts. A large capacity tray of the same size as the chopper case is a feature of the new machine. All gears are mounted on tapered roller bearings floating in oil, including thrust bearing, eliminating washer and power loss. The new chopper is powered by a ¾ h.p. specially built motor and is finished in burnished aluminum and white enamel. **The Biro Mfg. Co., Dept. MH, Marblehead, Ohio. (Key No. 617)**

Small Dishwashers

Two new dishwashers for small hospitals or diet kitchens have been developed by the General Electric Company. A pump assembly allows the appliance to be installed anywhere in the kitchen without direct connection to the drain line. Pump conversion kits are also available for use on standard line dishwashers. **General Electric Co., Dept. MH, Bridgeport 2, Conn. (Key No. 618)**

Model 435 Mimeograph

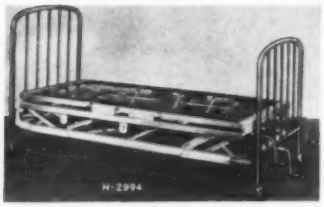
The mimeograph operator can now sit in a standard office chair while working at her machine. The new Model 435 Mimeograph with Flexamatic control is a table model, electric-drive unit for use with all makes of suitable stencil duplicating products. Mounted on rubber feet, the Model 435 can be placed on a table, a desk or on the Model 27 stand with built-in "start and stop" foot-control or on the Model 22 cabinet with large enclosed storage space for supplies and pull-out shelf.

The machine is highly economical and efficient for general use and specialized mimeographing procedures. It should prove especially adaptable for house organs, general forms, personnel instructions and many other uses in the hospital. A number of new features add

to its efficiency and ease of operation. **A. B. Dick Co., Dept. MH, 720 W. Jackson Blvd., Chicago 6. (Key No. 619)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Hall Invalid Bed



The new Hall invalid bed is standard home height of 18 inches for regular use but the entire bottom is easily raised by a central crank to regulation hospital bed height of 27 inches for nursing care or medical examination. Especially useful for convalescent and chronic cases, the bed has adjustable Gatch bottom which allows secure back support for sitting or reclining positions at numerous angles, and several positions for leg ease. Both back rest and knee support sections are joined to the center section by flat hinges which eliminates the necessity of lengthening or shortening the frame.

All positions are attained with the least disturbance to the patient and the easy turning handles and smooth elevating and lowering mechanism save exertion for the nurse or attendant. Known as Hall No. 2994 Invalid Bed, the new unit is finished in hard baked enamel, white or colors, with 1½ inch round posts. A similar bed, No. 2995, has the same specifications except that the 1½ inch posts are square and can be finished in wood grain as well as white and colors. **Frank A. Hall & Sons, Dept. MH, 200 Madison Ave., New York 16. (Key No. 620)**

Room Air Conditioner

A new console type room air conditioner, with two-tone, mar-resistant brown finish, has been announced. Known as the 51H2 DeLuxe, the unit includes a special exhaust control for the quick removal of stale air and a two-speed fan for draftless air distribution. The new unit is designed for quiet operation and refrigerating compressor and motor are hermetically sealed and require no oiling. **Carrier Corp., Dept. MH, Syracuse, N. Y. (Key No. 621)**

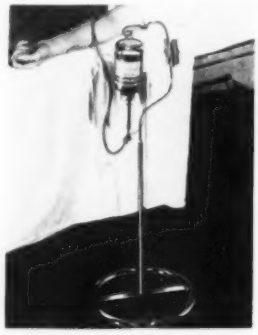
Vacuum Cleaner

A new vacuum cleaner has been announced which has been designed especially for hospital use. It is relatively silent in operation through the addition of extra mufflers inside the hood. Tank, hose and motor hood are finished in white with other parts of the machine nickel plated.

The machine operates on wet or dry pickup without change over and it has neither filter pans nor bags to empty. The bronze wool filter is easily cleaned and is designed for long wear. The 1 h.p. universal motor is sealed against water and dirt. The ball-bearing rubber-tired casters make the vacuum readily mobile and it is light in weight and sturdily constructed. It is available in 14 and 20 gallon capacity sizes and has a wide selection of attachments to convert quickly to any blower or vacuum job. **Multi-Clean Products, Inc., Dept. MH, 2277 Ford Pkwy., St. Paul 1, Minn. (Key No. 622)**

Blood Donor Standard

A new chrome plated portable blood donor standard has been developed to



save nursing time, assure safe blood drawing and ensure the nurse freedom of movement. The blood bottle is firmly held and the flexible standard makes it easy to agitate the bottle when desired. The stand is demountable, light in weight, and easy to use with both tables and cots. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 623)**

Stepunaire Waste Can

An air valve control of the cover permits closing of the new Stepunaire waste can without noise and permits regulation of the speed of closing. The noiseless pneumatic closing valve incorporates the principle of the pneumatic door check so that the speed of the cover can be controlled by means of an adjustable thumb screw.

The can has an inner container of seamless drawn stainless steel which facilities cleaning and eliminates cracks or crevices which might hold dirt or bacteria. A bale handle facilitates removal of the inner container for emptying and cleaning. **Hercules Food Service Equipment, Inc., Dept. MH, 1075 Metropolitan Ave., Brooklyn 6, N.Y. (Key No. 624)**

35 mm. Camera

The Foton is a new 35 mm. still camera which is fully automatic. A built-in spring motor advances the film and also winds the shutter. Both single frame and rapid sequence pictures can be made at any shutter speed and a burst of 15 frames can be taken in rapid sequence at the rate of four or five per second.

The Foton uses either 18 or 36 exposure standard 35 mm. film cartridges and the entire back of the camera opens to permit easy loading, cleaning or inspection. The shutter speed dial has positive calibrations for both slow and fast speeds and the shutter can be set with the camera either wound or unwound. **Bell & Howell Co., Dept. MH, 1803 Larchmont, Chicago 13. (Key No. 625)**

Microfilm File

The new No. 8936R Microfilm File has been developed as the result of consumer surveys and collaboration with several manufacturers of microfilm equipment and film. It is an upright file with nine progressive roller suspension drawers having a total capacity of one hundred 16 mm. or sixty-eight 35 mm. film reels per cabinet. Film drawers are partitioned to provide for four rows of film reels and each compartment has its own channel lever compressor.

Humidity is registered and controlled through an especially porous humidifying brick, that needs to be wet down only occasionally, in a drawer beneath the bottom film drawer and a Humidiguide gauge located in the face of the bottom film drawer. Thus too-moist or too-dry conditions can be checked and controlled to ensure safe-keeping of the film.

The file cabinets are available in both olive green and Neutra-Tone gray finishes with white metal drawer pulls and

label holders, with or without cabinet lock. **Yawman & Erbe Mfg. Co., Dept. MH, Rochester 3, N. Y. (Key No. 626)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Lens for Medical Photography

A conveniently placed depth of field scale and easy-to-read markings are features of the new Kodak Cine-Ektar lens, 25 mm. f/1.4 which has been designed to provide professional quality for the medical photographer. The new lens was developed to help improve the technical quality of medical motion pictures and incorporates Kodak's new optical glass lumenized with Kodak's ultra-hard lens coating.

Seven glass elements provide better definition and resolution at f/1.4 and the lens gives a flatter field and a long back focus. Adapters are available to fit the new lens to any 16 mm. cine camera. The new lens will focus sharply on objects as close as 12 inches from the film plane, it has a new type of iris diaphragm and the non-rotating barrel permits all readings to be made by looking down on the lens. **Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 627)**

Facing Tile Colors

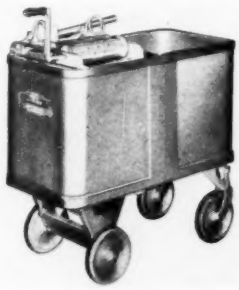
The Chromatic Line of ceramic glaze structural facing tile contains nine new colors to provide flexibility in design and decorative harmony. Field shades include Venetian Cream, Colonial Mottle, Blush Coral, Blush Coral Mottle, Spring Yellow, Pewter Gray, Gulfstream Green, Glacier Green and Silver Pine Mottle. Trim shades are Chocolate, Fall Red and Ebony. **Metropolitan Paving Brick Co., Dept. MH, Canton, Ohio. (Key No. 628)**

Sink Line Cleaner

The new Model 600 Spartan Electro-Rod sink line cleaning machine has a new powerful, reversible motor with new gear train mounted on hardened and ground shafts rolling in needle bearings, 3 conductor cord providing ground wire and a new off-on switch which is designed to prevent shock. The compact unit is so designed that the operator can hold and guide both the power unit and the cable with one hand and is small enough to be held up to inaccessible cleanouts. It is designed for rodding lines and pipes from 1 to 4 inches in diameter and has a capacity of 100 feet of ½ inch sewer cable. Attachments permit cleaning, scraping or brushing condenser tubes, process lines and water boiler piping. **Spartan Tool Co., Dept. MH, 6007 N. Lincoln Ave., Chicago 45. (Key No. 629)**

Finnell Mop Truck

The recently introduced Finnell Mop Truck has rounded corners and recessed wheels which permit it to be used in small spaces and which save space when stored. The truck has two 20 gauge galvanized tanks, each with a capacity of 28 gallons, and No. 6 rubber plug outlets discharge beneath the tanks. The 3 inch steel wringer rolls have a wringer pressure of 75 pounds.



A feature of the new truck is a mop shield beneath the wringer which prevents mops from dropping into dirty water when being wrung. The truck rolls on 4 double-disc pressed-steel wheels, two of which swivel for easy maneuvering. The truck is ruggedly constructed to withstand hard usage and is available in stainless steel or galvanized iron. **Finnell System, Inc., Dept. MH, Elkhart, Ind. (Key No. 630)**

Instrument Kit

A new instrument kit has been developed which is made entirely of Monel metal and thus can be placed, complete with instruments, in the autoclave. The case has two drawers which open with the lid and the Grip-Loc handle which can only be opened when the handle has been pushed down, unlocking the top of the box from the top shelf. Special instruments for staff specialists can be stored in individual kits, ready for immediate use. The kits are available in two sizes, 7 by 7 by 16 inches and 7 by 7 by 21 inches. **Watson-Sharp & Co., Dept. MH, West Chicago, Ill. (Key No. 631)**

Bookkeeping Machines

The new line of bookkeeping machines, known as the "Foremost" 500 and 600 series, has been developed in modern, functional design. New features include a streamlined, non-glare case; finger-grooved, organ-type keys for simpler operation; optical lucite covering the registers which magnifies all figures for increased visibility, and special insulated, noise-absorbing Aphonic Stand to reduce operator fatigue and prolong machine life. All models in the new design are completely electrified.

Two, three or more related forms may be produced at one time on the new machines and many specific applications may be handled on one machine since the operator can add, remove or reposition registers in a matter of seconds. Front feed insertion and collation permit one procedure operation. **Remington Rand, Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 632)**

Lighter for Bunsen Burners

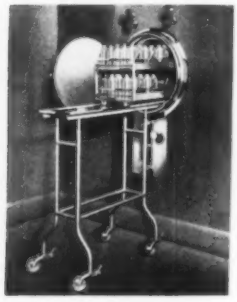
The Irving Liter is designed to be attached firmly and permanently to the tube of any Bunsen Burner from ⅜ to ⅝ inch o.d. Only one hand is required to light the burner with the Irving Liter thus leaving the other free. The Liter eliminates the need for matches and is ready for instant use at all times. **W. M. Welch Scientific Co., Dept. MH, 1515 Sedgwick St., Chicago 10. (Key No. 633)**

Tube Cutter

The maintenance department will be interested in the new tube cutter recently announced, with "free wheeling" ball-bearing action, which is designed for use with copper, brass, aluminum, Bundy steel, block tin and lead tubing. It will cut all sizes from ⅛ to 1 inch outside diameter inclusive. A retractable locking reamer for reaming tubing after it is cut is a feature of the cutter which has an overall length of only 4½ inches. The reamer folds out of the way when not in use and the tool weighs only 6 ounces and is known as No. 274-F. **The Imperial Brass Mfg. Co., Dept. MH, 1200 W. Harrison, Chicago 7. (Key No. 634)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Formula Autoclaves



New autoclaves in 3 sizes, designed for the preparation of formulas for newborn infants and formed by two Monel or brass shells which are riveted and sweated to a cast bronze door, have recently been announced. Available for either recessed or exposed installation, they are of the pressure-vacuum type, steam jacketed, for operation by steam, gas or electricity at 5 to 20 pounds pressure. Capacities are 40, 100, and 160 8-ounce or 4-ounce bottles. **The Ohio Chemical & Mfg. Co., Dept. MH, 1400 E. Washington, Madison 10, Wis. (Key No. 635)**

Small Dishwashing Machine

The new Ensign dishwasher has been designed for use in small hospitals, diet kitchens, nurses' homes and other places with a capacity of approximately 100 persons per meal. The new Model No. 40 is sturdy, compact and easy to operate. It is designed to fit into the dish table and all parts are readily accessible for cleaning.

Features of the new model include: double ball-bearing "packless" pump; single lever control for both wash and rinse, thus meeting sanitation requirements, and upper and lower wash and rinse sprays constructed with new "water flow" control design. The machine is available in either manual or automatic control, the automatic control operating on a time cycle to guarantee correct intervals for thorough washing and rinsing. **Insinger Machine Co., Dept. MH, 6245 State Rd., Philadelphia 35, Pa. (Key No. 636)**

Pot and Pan Washer

The "Panhandler"—Model K is a compact pot and pan washer designed for hospital and other institutional use. The unit washes and rinses pans, kettles, steam table pans, baking pans and other cooking utensils from above and below. The wash operation is performed with th Alvey-Ferguson "Super Spray" pressure system. It features an automatic hold down grid, automatic wash timer, uniform rinse and wash-rinse cycle signal with screen tanks and interlocked door.

The attractive washer, finished in white with stainless steel surface door, occupies only 6 feet by 5 feet 4 inches of floor space and has a tray size for a large load. The machine is designed to accommodate all sizes and types of utensils including an 80 quart mixing bowl. **The Alvey-Ferguson Co., Dept. MH, Cincinnati 9, Ohio. (Key No. 637)**

Automatic Orange Juicer

An electrically operated machine which cuts oranges, squeezes and strains the juice all in one operation has recently been announced. Dispensing juice at the rate of 18 oranges per minute, automatically discharging the skin, pulp and seeds into a disposal unit, the Morey Automatic Orange Juicer should prove especially practical for use in hospitals. An adjustable chute allows oranges of all sizes, limes or grapefruit

to be squeezed at the same rate of speed.

The body of the juicer is made of aluminum and all metal parts that come in contact with the juice are of stainless steel. The unit is powered by a ¼ h.p. motor and can be completely dismantled, cleaned and ready for immediate re-use in approximately one minute. **Morey Food Machinery Co., Dept. MH, 30 Church St., New York 7. (Key No. 638)**

Fire Alarm System

A new fire alarm system for institutions where public safety is paramount has been introduced as the Type SA Master Code Fire Alarm System. This closed circuit type system consists of break-glass, non-code fire alarm boxes, fire alarm signals and a control panel. Electrical supervision of all signals, boxes, resistance units, winding of relays and the motor used to drive the coding mechanism ensures reliability of the unit. **The Autocall Company, Dept. MH, Shelby, Ohio. (Key No. 639)**

Freezer-Coolers

A new line of 2 temperature, prefabricated, walk-in freezer-coolers has been developed especially for institutional use. The new units are constructed of light weight, heavily insulated aluminum clad sections which are designed to be rapidly assembled even by inexperienced personnel and are available in a number of sizes. The freezer compartments are designed to hold a generous supply of frozen foods and the cooler compartments for storage of meats, vegetables and other foods.

The four models now available range in size from 110 cubic feet of freezer storage and 232 cubic feet of cooler space to 162 cubic feet of freezer storage and 860 cubic feet of cooler space. The coolers can be equipped with heavy duty refrigeration systems to permit sharp freezing of approximately 300 pounds of food per day if desired. **Refrigeration Engineering Corp., RECO Products Div., Dept. MH, 2020 Naudain St., Philadelphia 46, Pa. (Key No. 640)**

Liquid Soap Dispenser

The new Bobrick liquid soap dispenser was developed by a leading industrial designer to combine attractiveness and functional simplicity. Known as the Bobrick 24, the streamlined hood and all working parts are of stainless steel. The mechanism is completely demountable and replaceable without the use of any special tools. The shatterproof soap container is made of Lustrex which is impervious to all soaps and, being translucent, the level of the soap is readily visible. The mechanism, known as Bobrick HydroFlex, is designed to give trouble-free service indefinitely. The concealed wall fastening guards against theft and the newly designed, locked filler-cap is chained to the dispenser. The Bobrick WallPlad permits attaching the new dispenser to any hard surface wall without screws in less than 3 minutes, or it may be attached by conventional methods.

Bobrick Mfg. Corp., Dept. MH, 1839 Blake Ave., Los Angeles 26, Calif. (Key No. 641)

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Penicillin Inhaler

A powder inhaler has been developed by Upjohn for use in penicillin inhalation therapy. Of simple construction, the new inhaler is easy to use and readily cleaned. It consists of three parts, a barrel and capsule well of transparent plastic and a rubber bulb. The inhaler has been designed to produce an even, finely powdered suspension of penicillin in air for the uniform distribution of the antibiotic throughout the respiratory tract, accomplished by the patient's inhalation. It is designed for use with Upjohn's Inhalation Penicillin, each capsule containing 100,000 units of crystalline penicillin G. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 642)**

Wood-Grained Wall Panels

Wood-grained panels on a base of tempered Presdwood have been developed to give the effect of wood paneling when used on walls. Known as Ser-Wall, the panels offer structural strength and insulation qualities as well as attractive appearance. The realistic wood-graining is achieved through a lithographing operation and is sealed by a coating of clear lacquer. The panels are easily kept clean with mild soap and water and do not peel, chip or crack. No finish is required on Ser-Wall panels.

Ser-Wall panels are now available in cross-fired figured walnut and in bleached walnut with other wood-grain finishes being developed. **Service Products Div., Woodall Industries, Inc., Dept. MH, 2035 Calumet Ave., Chicago 16. (Key No. 643)**

Micro X-Ray Recorder

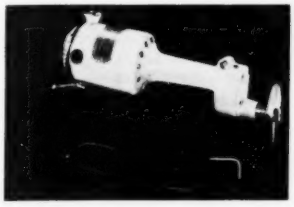
A new automatic machine, known as the 35 mm. Micro X-Ray Recorder, has

been developed to record x-rays, photographs, specimens and other types of material on a continuous 100 foot roll of 35 mm. film, automatically controlling all densities and detail contained in the original. All x-rays recorded are within 97 per cent of perfection to that of the original in all densities, thus making it possible to store x-rays on micro-film.

Originally designed for recording x-ray films, the unit can also be used by small hospitals to record the accompanying case histories. Cost of operation is low enough so that the machine should pay for itself within a reasonable length of time. It has two coverage areas, 17 by 21 inches and 10 by 12 inches. Any recorded image may be immediately located for reference with the use of the 35 mm. photo-roentgen film viewer. The Recorder is available through leading x-ray equipment manufacturers and distributors. **Micro Equipment Corp., Dept. MH, 1941 N. Western Ave., Chicago 47. (Key No. 644)**

Stryker Autopsy Saw

The new Stryker Autopsy Saw is electrically driven and provides all the advantages of high speed oscillation. It



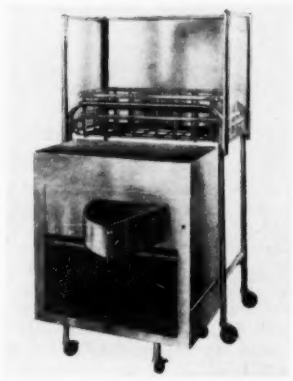
is safe and sanitary, since the cutting teeth are so designed that they do not throw material and do not cut soft tissue or skin unless restrained from oscillating action. It cuts rigid bone efficiently without danger to the operator and the 2 sided blade can be quickly adjusted to 3 positions.

The saw is light in weight, weighing less than 4 pounds. The handle is near the blade for good control and balance. It cuts on forward and backward strokes and the blade, arbor and shaft are of stainless steel. The new saw is not designed for boiling or autoclaving. **Orthopedic Frame Co., Dept. MH, Kalamazoo, Mich. (Key No. 645)**

Snap-On Mask

A face mask which snaps on and off instantly has been developed for cool, comfortable protection. Made of Texkon, the masks can be sterilized in boiling water, live steam or autoclaves and are inexpensive enough to be disposable after use. They may be washed and sterilized for repeated use if desired. **Martin Products Co., Dept. MH, 243 Broadway, Brooklyn 11, N. Y. (Key No. 646)**

Glass-Sided Bassinet



Cubicle-type design with safety glass panels on three sides and individual dressing tables are improvements offered in two models of Blickman bassinets to give additional protection to infants against air-borne and cross-infection. In the Bergman model, one glass side lowers to provide easy access to the infant and the dressing table pulls out from the narrow side. In the Mercy unit the cabinet slides forward, its top serving as the individual dressing table. A specially-designed quarter-circle drawer swings out for easy access.

Both units have a large storage compartment with disappearing type door for linen and other supplies and both are available in either enameled or stainless steel. Because of the compactness, mobility and protection from drafts and air-borne infection provided by the cubicle-like glass panels, both units are especially suited for use by hospitals employing the rooming-in technic. **S. Blickman, Inc., Dept. MH, Weehawken, N. J. (Key No. 647)**

Disc Voicewriter

The new Disc Edison Voicewriter is a new dictating instrument combining convenience with the Edison "Ear-Tuned Jewel-Action" diction control. Thirty minutes of dictation can be recorded on each 7 inch vinylite plastic disc which can be mailed if desired. The disc slips into the machine for recording and is automatically positioned. It can be erased by spinning at high temperatures. A special electronic circuit makes the speaker's voice more understandable and a warning light blinks if no disc is in the Voicewriter, if the cover is not down so that the disc is firmly held or if the instrument is not set on dictation. An accurate locating pointer enables the dictator to find his place quickly when desired. **Thomas A. Edison, Inc., Dept. MH, West Orange, N.J. (Key No. 648)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Aluminum Slide Binder

The new GoldE "Snap-It" aluminum 2 by 2 inch slide binder is designed to permit easier, faster mounting of 35 mm. color or black and white film. The film is placed between the two pieces of glass in the binder and the binder snaps them together. The film is self-centering and is held firm and flat.

The aluminum binder has round corners, is shockproof and dustproof and provides protection for color transparencies. It can be reused since the film is readily snapped out and another put in. The binder is light in weight, easy to store or carry in quantity and has an identification panel for projection guide. **GoldE Mfg. Co., Dept. MH, 1222 W. Madison St., Chicago 7. (Key No. 649)**

Aluminum Door Closer

The new "broad-shouldered" Norton door closer has a permanent mold aluminum case. The resulting light weight makes possible speedy and economical installation. The new closer has had exhaustive field and factory tests equivalent to 20 years of continuous use without interruption.

The new aluminum closers are of the rack and pinion hydraulic type, which gives positive door control at every point in the movement of the door, and have all steel interior parts. The closers have a leakproof shaft, new oil-lite bottom bearings, 50 per cent greater bearing surface, two speeds of regulation on one screw and holder arms that permit the door to be held at any desired opening. Made in all standard sizes with 6 types of holder arms and 7 bracket styles, the new Norton closers are finished in gold, aluminum and bronze or in standard brown, black or prime coat. **Norton Door Closer Co., Dept. MH, 2900 N. Western Ave., Chicago 18. (Key No. 650)**

Cardoplate Self-Writing Record

The new "Cardoplate Self-Writing Record" has been developed to help cut costs and reduce time in hospital and clinic record keeping procedures. It embodies the use of a light weight embossed metal plate which can be attached to standard accounting forms, making it possible to add the features of an Addressograph plate to a basic accounting record.

A new portable transcribing unit, known as Addressograph Model 125, has been introduced for use in conjunction with the Cardoplate self-writing unit. The small, compact machine can be operated on any convenient stand, desk or table. **Addressograph-Multigraph Corp., Dept. MH, 1200 Babbitt Rd., Cleveland 17, Ohio. (Key No. 651)**

Pharmaceuticals

Benadryl Hydrochloride Cream

For topical antihistaminic action, Benadryl Hydrochloride Cream is a soothing, smooth, easy to apply, stainless product containing 2 per cent of Benadryl hydrochloride in a cream which is miscible with water and is easily removed from sensitive skin surfaces without using soap or other detergent. It is indicated for the relief of itching associated with many dermatoses, sunburn, minor skin irritations and even as a powder base for patients allergic to cosmetics. It is supplied in 2 ounce tubes. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 652)**

Mosidal

Mosidal is the Abbott trade mark for ethyl-beta-methylallylthiobarbituric acid, which has been found to exert a protective and therapeutic action against motion sickness in human beings, without undesirable side-effects. It is designed for the prevention and treatment of nausea produced by the motion of automobiles, trains, ships and other carriers. It is a prescription product supplied in 0.15 Gm. tablets in bottles of 25 and 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 653)**

Penettes

Penettes are a penicillin chewing gum in which penicillin is said to remain stable for a year or more at room temperature and which duplicate the flavor of non-medicated chewing gum. Uncoated pieces with a peppermint flavored chicle base, each of the Penettes contains 10,000 units of penicillin. It is designed for treatment of Vincent's infection and as an adjunct for treating minor superficial dental infections caused by penicillin-sensitive organisms. Chewing brings about effective distribution of penicillin in the mouth. **Bristol Laboratories Inc., Dept. MH, Syracuse 1, N.Y. (Key No. 654)**

Pyribenzamine Expectorant

Pyribenzamine Expectorant with Ephedrine is a new non-narcotic cough syrup designed for treatment in cases of upper respiratory infection associated with allergy to relieve the accompanying cough and to control respiratory symptoms. It is also used in controlling the persistent cough frequently accompanying bronchitis due to or associated with allergy. It is a pleasant tasting syrup supplied in 1 pint and 1 gallon bottles. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N.J. (Key No. 655)**

Urecholine Chloride

A new and potent parasympathomimetic drug, Urecholine Chloride is indicated for the prevention or alleviation of gastric retention, urinary retention and abdominal distention due to muscular atony without obstruction. The product is said to be effective when given orally as well as after subcutaneous administration. It is supplied in 5 mg. tablets in bottles of 100 and in 1 cc. ampules, 5 mg. per cc., 6 ampules per carton. **Merck & Co., Inc., Dept. MH, Rahway, N. J. (Key No. 656)**

Bi-Pen

Bi-Pen is a dual penicillin preparation with properties common to both insoluble repository penicillin salts and soluble crystalline penicillin salts. Each dose, for intramuscular injection, consists of 300,000 units of crystalline procaine penicillin G and 100,000 units of buffered crystalline penicillin G potassium which leads to high initial penicillin blood levels and prolonged absorption for 24 hours. Supplied as a dry powder which is stable in the original vial for 18 months at room temperature, Bi-Pen mixes promptly with sterile distilled water for injection. **C.S.C. Pharmaceuticals, Division of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 657)**

Gramozets

Gramicidin, the principal active fraction of the antibiotic agent, tyrothricin, is available in antibiotic anesthetic troches known as Gramozets. Each troche contains gramicidin and benzocaine in a palatable, long-lasting base. Designed for the relief of throat irritations and infections of the throat and mouth due to gram-positive organisms, Gramozets are supplied in tubes of 12 troches, 12 tubes to the carton. **Schering Corp., Dept. MH, Bloomfield, N.J. (Key No. 658)**

Tronic Compound

Tronic Compound is a pleasantly flavored vitamin B complex, amino acid preparation designed for dietary supplementation and vitamin B therapy. Containing the natural factors of vitamin B complex, the important minerals of calcium, potassium and manganese fortified with the essential amino acids, the new product is indicated in the treatment of postoperative convalescence, debilitated states and the like and also as a dietary supplement for patients or elderly persons unable to eat properly and absorb sufficient amounts of essential vitamins. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 659)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Product Literature

• A new sound slide-film, **"Modern Commercial Dishwashing,"** has been produced by Wyandotte Chemicals Corp., Wyandotte, Mich., to illustrate recommended methods for both hand and machine washing of glassware, dishes and silverware. Procedures are based on extensive laboratory tests and the film is designed as an educational service to those concerned with food service. Arrangements for showing the film can be made through Wyandotte district offices and a 24 page booklet, which parallels the film in pictures and instructions, is also available. **(Key No. 660)**

• **"Communicable Diseases"** is the title of a 16 mm. color and sound educational motion picture produced by Cutter Laboratories, Berkeley 10, Calif., for showing to health and hospital groups. Filmed in the isolation hospitals at Los Angeles, San Francisco and Oakland, California, the film is 35 minutes in length and can be shown on any standard sound projector. **(Key No. 661)**

• The new **1949 Catalog 86** issued by The Sanymetal Products Co., Inc., 1701 Urbana Rd., Cleveland 12, Ohio, shows 5 types of Sanymetal Toilet compartments and toilet room environments in colors. Construction details, specifications, hardware and a description of the materials used are included as well as a color chart and 21 color chips to illustrate the wide variety of colors available in these toilet compartments. **(Key No. 662)**

• **"Make the Most of Daylight With PC Functional Glass Blocks"** is the title of a helpful 16 page booklet on the control of natural daylight through the use of functional glass block fenestration issued by the Pittsburgh Corning Corp., 652 Duquesne Way, Pittsburgh 22, Pa. Included are data on types of functional blocks and their uses, brightness data, light transmission and distribution, daylight control and a picture section of typical installations. A complete technical data section is appended. **(Key No. 663)**

• The new edition of its **"Material Handling Equipment"** catalog has been issued by Washington Equipment & Supply Co., 810 W. Fulton St., Chicago 7. Descriptive information on hand trucks, restaurant service trucks, dressing carriage and shelf trucks, mopping trucks, dollies, conveyors and casters is given in detail. **(Key No. 664)**

• The varied uses of bronze plaques and signs are described in a 28 page booklet, **"Bronze Tablets,"** issued by United States Bronze Sign Co., Inc., 570 Broadway, New York 12. **(Key No. 665)**

• **Catalog 104** covers the complete line of **"Instruments, Laboratory Specialties, and Teaching Aids for the Medical and Allied Sciences"** offered by Clay-Adams Co., Inc., 141 E. 25th St., New York 10. The attractively bound book contains 164 pages of descriptive and pictorial information with complete details and prices in addition to an alphabetical index and a cross index of catalog numbers. **(Key No. 666)**

• A new device, called the **Color Calibrator,** has been developed to assist in the selection of colors for room decoration. It automatically picks out and harmoniously assembles as many as 6 different hues at the same time, to reveal a complete color scheme for a room or a unit. Produced by Pratt & Lambert, Inc., 75 Tonawanda St., Buffalo 7, N. Y., manufacturers of paints and varnishes, the device was designed and patented by Sterling B. McDonald, color authority. An instruction booklet to explain how the best results may be obtained, accompanies the Color Calibrator which is available at all Pratt & Lambert paint and varnish dealers throughout the United States and Canada. **(Key No. 667)**

• **Bulletin No. 201, "Safety Type Service Equipment" and Bulletin No. 302, "Dustite Light and Power Panelboards,"** have recently been published by the Frank Adam Electric Co., P. O. Box 357, St. Louis 3, Mo. Descriptive information, illustrations, specifications and diagrammatic drawings on the electric service equipment manufactured by this company are included in the bulletins. **(Key No. 668)**

• The various types of Morse Boulger Destructors and Kernerators for handling all kinds of waste, garbage and refuse, with details as to capacities, sizes and dimensions are described in a new 8 page **bulletin (No. 174)** issued by Morse Boulger Destructor Co., 205 E. 42nd St., New York 17. **(Key No. 669)**

• A new booklet, **"Canned Foods in the Economic Spotlight,"** presents the results of a 12 month research study conducted by 19 leading American universities on the comparative cost and availability of 12 of the most frequently consumed fruits and vegetables. The booklet has been issued by the Can Manufacturers Institute, 60 E. 42nd St., New York 17. **(Key No. 670)**

• Full details on the **Olson line of food service conveying equipment,** including tray conveyors, under counter conveyors, dishrack conveyors and the subveyor for automatically raising and lowering food and dishes between floors are given in a new 12 page booklet issued by Samuel Olson Mfg. Co., Inc., 2418 Bloomingdale Rd., Chicago 47. **(Key No. 671)**

• The **"Want Book"** recently issued by Edward Weck & Company, Inc., 135 Johnson St., Brooklyn 1, N. Y., is a supplement to Weck catalog No. 46 and is issued as a service to those concerned with new instruments, instrument repairs and surgical supplies. The back cover lists all items alphabetically and a pocket in the front cover carries postage paid order cards and leaflets on "Meding Tonsil Enucleator," "Wectex 'guaranteed' Gloves," "Wexteel Needles," "Weck Open-Ring Scissors" and other items. The book itself is a series of lined pages, blank except for the ruling and the headings of "quantity" and "description," for listing needs as they arise. **(Key No. 672)**

• **Technical Bulletin No. 1** issued by Sarcotherm Controls, Inc., 350 Fifth Ave., New York 1, is the first of a series of bulletins designed to assist architects and engineers in selecting the appropriate controls for radiant heating systems. Descriptions and wiring diagrams of thermostats developed especially for radiant heating are included. **(Key No. 673)**

• Armstrong steam humidifiers for automatically controlling relative humidity are described in **Humidifier Bulletin No. 1771** issued by Armstrong Machine Works, Three Rivers, Mich. The effect of relative humidity on human comfort and health is discussed as well as how maintenance of proper humidity will eliminate the fire and explosion hazards of static electricity. **(Key No. 674)**

• Practical hints on correct technics in the care and use of dry cotton mops for sweeping floors are offered in the revised edition of Bulletin No. 25, **"How to Sweep Floors With a Cotton Mop,"** issued by G. H. Tennant Co., 2530 N. Second St., Minneapolis 11, Minn. The advantages of cotton mop sweeping, methods of treating and cleaning a mop and other helpful suggestions are included. **(Key No. 675)**

• The complete line of **Onan Electric Plants,** including many new models, is covered in a new 20 page, 2 color catalog issued by D. W. Onan & Sons Inc., Minneapolis 5, Minn. A model guide, written in easy-to-read style, is included in the booklet to assist in the selection of the right electric plants for every need. **(Key No. 676)**

• The story of **"Prufcoat Protective Coatings"** is told in a folder and leaflets issued by Prufcoat Laboratories, Inc., 50 E. 42nd St., New York 17. Included is the story of how this acidproof, alkaliproof, alcohol-proof, oilproof, waterproof, and flameproof coating has been used in a hospital humidity room and has withstood several years of service and repeated washing with strong cleaning agents. **(Key No. 677)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

• Historical data on the penetration of America via the Hudson River and the subsequent development of the area around Albany are given in an attractively laid out and printed booklet, **"Historic Rensselaer,"** published by F. C. Huyck & Sons, Kenwood Mills, Rensselaer, N. Y. The text is illustrated by clever drawings reproduced in black with a wash color plate. The founding of Kenwood Mills and the progress and development of the company make interesting reading while clever sketches show the steps in the development of Kenwood Blankets. **(Key No. 678)**

• Two new catalogs of hospital and medical supplies and equipment have been published by the Max Wocher & Son Co., 609 College St., Cincinnati 2, Ohio. One catalog, **Hospital Surgical and Nursing Equipment,** covers the complete Wocher line of equipment for operating, emergency, delivery, out-patient and treatment rooms in hospitals and medical centers. The second catalog, **The Physicians and Surgeons Instrument and Supplies Catalog,** includes all supplies for physicians and surgeons including x-ray accessories. Both catalogs are fully illustrated. **(Key No. 679)**

• A most interesting 54 page booklet has been published by The Trane Company, La Crosse, Wis., with the title **"Merely a Matter of Air."** It is described as the story of the evolution of air conditioning and presents the material most effectively in well laid out pages printed with attractive type and with attention-compelling sketches supplementing the text. The book provides basic factual information in a most attractive form. **(Key No. 680)**

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Bessie Covert,
Editor, "What's New for Hospitals"

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- ☐ 625 35 mm. Camera
- ☐ 626 Microfilm File
- ☐ 627 Lens for Medical Photography
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- ☐ 630 Finnell Mop Truck
- ☐ 631 Instrument Kit
- ☐ 632 Bookkeeping Machines
- ☐ 633 Lighter for Bunsen Burners
- ☐ 634 Tube Cutter
- ☐ 635 Formula Autoclaves
- ☐ 636 Dishwashing Machine
- ☐ 637 Pot and Pan Washer
- ☐ 638 Automatic Orange Juicer
- ☐ 639 Fire Alarm System
- ☐ 640 Freezer-Coolers
- ☐ 641 Liquid Soap Dispenser
- ☐ 642 Penicillin Inhaler
- ☐ 643 Wood-Grained Wall Panels
- ☐ 644 Micro X-Ray Recorder
- ☐ 645 Stryker Autopsy Saw
- ☐ 646 Snap-On Mask
- ☐ 647 Glass-Sided Bassinet
- ☐ 648 Disc Edison Voicewriter
- ☐ 649 Aluminum Slide Binder
- ☐ 650 Aluminum Door Closer
- ☐ 651 Cardoplate Self-Writing Record
- ☐ 652 Benadryl Hydrochloride Cream
- ☐ 653 Mosidal
- ☐ 654 Penettes
- ☐ 655 Pyribenzamine Expectorant
- ☐ 656 Urecholine Chloride
- ☐ 657 Bi-Pen
- ☐ 658 Gramozets
- ☐ 659 Tronic Compound
- ☐ 660 "Modern Commercial Dishwashing"
- ☐ 661 "Communicable Diseases"
- ☐ 662 Catalog 86
- ☐ 663 "Make the Most of Daylight"
- ☐ 664 "Material Handling Equipment"
- ☐ 665 "Bronze Tablets"
- ☐ 666 Catalog 104
- ☐ 667 Color Calibrator
- ☐ 668 Bulletins No. 201 and 302
- ☐ 669 Bulletin No. 174
- ☐ 670 "Canned Foods"
- ☐ 671 Conveying Equipment
- ☐ 672 Weck "Want Book"
- ☐ 673 Technical Bulletin No. 1
- ☐ 674 Bulletin No. 1771
- ☐ 675 Bulletin No. 25
- ☐ 676 Onan Electric Plants
- ☐ 677 "Prufcoat Protective Coatings"
- ☐ 678 "Historic Rensselaer"
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- ☐ 680 "Merely a Matter of Air"
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- ☐ 682 Books

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Book Announcements

J. P. Lippincott Company, E. Washington Square, Philadelphia 5, Pa. Levinson, "Symposium of Medicolegal Problems—Vol. II," $5. **(Key No. 681)**

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Bookmiller and Bowen, "Textbook of Obstetrics and Obstetric Nursing," 737 pp., $4.50. Ingram, "Principles of Psychiatric Nursing," 3rd Ed., 525 pp., $3.75. **(Key No. 682)**

Suppliers' News

Airkem, Inc., manufacturer of odor counteracting and air freshening products, announces removal of its offices and plant from 7 E. 47th St. to **241 E. 44th St., New York 17.**

C. A. Dunham Company, 400 W. Madison St., Chicago 6, manufacturer of heating systems and products, announces completion of an addition to its Michigan City, Ind., factory. The new building will be used for storage of finished products just prior to shipment and to house the order and billing departments, formerly located in Chicago.

Marsh Wall Products, Inc., Dover, Ohio, manufacturer of "Marlite" plastic-finished wall and ceiling panels, announces completion of a new building program to provide greatly expanded facilities for production. The building program is part of the expansion plan announced when Marsh became a subsidiary of the Masonite Corp.

National Paper Products, 122 E. 42nd St., New York 17, manufacturer of paper products, announces change of name to **Nata Products Co., Division of Crown Zellerbach Corp.**

The Quicap Co., Inc., manufacturer of sanitary covers for nursing and other bottles, announces removal of its offices from 233 Broadway to **441 Lexington Ave., New York 17.**

United States Rubber Co., 1230 Avenue of the Americas, New York 20, manufacturer of foam rubber mattresses and rubber sundries, announces removal of its Chicago offices, serving five midwestern states, from 440 W. Madison St., to **The Merchandise Mart, Chicago 54.**

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